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| flat black 1 | | | | | | | | | Authorization for the Use and/or **Disclosure of Protected Health Information** | | | | |
| **EXPLANATION** | | | | | | | | | | | | | | |
| This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the federal HIPAA privacy regulations, 45 C.F.R. § 164.508 and the Confidentiality of Medical Information Act, Cal. Civ. Code § 56 et seq. or other applicable state law. | | | | | | | | | | | | | | |
| **AUTHORIZATION** | | | | | | | | | | | | | | |
| 1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization. | | | | | | | | | | | | | | |
| Statements/testimonial made by me on [ENTER DATE HERE] with respect to my participation in [ENTER NAME OF PROGRAM HERE] and/or information based on those statements; provided, however, that use and/or disclosure to those identified in 3(A) shall be limited in the following manner: [Enter your specific instructions here, such as: no limitations, anonymous basis, name but no photo, first name only, first name with last initial, etc.] | | | | | | | | | | | | |
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| 2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information about me: | | | | | | | | | | | | | | |
| (A) Chevron Corporation, and | | | | | | | | | | | | |
| (B) Chevron Corporation’s workforce and Business Associates of the Omnibus Health Care Plan of Chevron Corporation who perform services with respect to the Chevron [ENTER NAME OF PROGRAM HERE] program. | | | | | | | | | | | | |
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| 3. I authorize the following persons (or class of persons) to receive my protected health information about me: | | | | | | | | | | | | | | |
| (A) Viewers/readers of materials relating to the Chevron [ENTER NAME OF PROGRAM HERE] program | | | | | | | | | | | | |
| (B) and Other parties identified in number 2 above. | | | | | | | | | | | | |
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| 4. I understand that, if my protected health information about me is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. | | | | | | | | | | | | | | |
| 5. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and delivered to: | | | | | | | | | | | | | | |
|  | | | . I am aware that my revocation is not effective to the extent that the | | | | | | | | | |
| persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization and that my revocation is not effective until my written notice of revocation has been received. | | | | | | | | | | | | | |
| 6. This authorization expires upon | | | | | |  | | | | (provide a date (mm/dd/yyyy) or an event which | | | | |
| triggers expiration of the authorization). | | | | | | | | | | | | | | |
| 7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment or with respect to a health care employee benefit plan, eligibility for the plan, enrollment in the plan, or payment of benefits under the plan. | | | | | | | | | | | | | | |
| 8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose): | | | | | | | | | | | | | | |
| **Name** | | | | | |  | **Explanation** | | | | | | |
| Parties identified in number 2 above. | | | | | |  | To promote, and/or to prepare materials promoting participation in the Chevron [ENTER PROGRAM NAME HERE] program by Chevron employees. | | | | | | |
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| **AUTHORIZATION SIGNATURES** | | | | | | | | | | | | | | |
| **I certify that I have received a copy of the authorization.** | | | | | | | | | | | | | | |
| Signature | | |  | | | | | | | | Date (mm/dd/yyyy) | |  | |
| Name of Patient (Print) | | | |  | | | | | | | |  | | |
| Name of Personal Representative (Print) | | | | | | | |  | | | |  | | |
| Relationship to Patient and Basis of Authority to Act on Patient’s Behalf | | | | | | | | | | | |  | | |
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