STATE OF CALIFORNIA
CALIFORNIA HEALTH BENEFIT EXCHANGE/COVERED CALIFORNIA (Exchange/CC)

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION & APPOINTMENT OF REPRESENTATIVE

HBEX 403 (07/17)

Authorization For Release of Personal Information & Appointment of Representative

This form authorizes Covered California to release your personal information to the parties specified in this request. To submit this request, please complete all necessary items and mail the completed form and all relevant documents to:

Privacy Officer
1601 Exposition Blvd.
Sacramento, CA 95815

Consumer Information

(As indicated on your Covered California Account)

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Account Number:		Date of Birth:
Daytime Phone Number:	Email Address	

Consumer Address Verification

(Please attached a copy of one of the following with your name and current address.)

California Driver's License ☐	Utility Bill ☐	Other ☐

Consumer Identity Verification

(Please attached a copy of one of the following. If no identifying document is attached, your signature must be notarized.)

California Driver's License ☐	State of California Identification Card ☐
Federal Issued I.D. Card ☐	Notary ☐
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

Consumer Authorization

By my signature, I hereby authorize Covered California, to release the following personal information to the individual or entity identified below:

Name of Individual or Entity:		
Street Address:	City and State:	Zip Code:
Day Time Phone Number:	Fax Number/Email Address:	
Purpose of Release:		

Consumer Appointment

☐ I would also like to appoint the individual identified above to serve as my Authorized Representative.

By checking this box, you are authorizing the individual identified above to make decisions pertaining to your Covered California account, which could potentially affect your healthcare coverage. If you do not wish for the person listed above to have this authority, please leave this box unchecked. Otherwise, please sign below and have your Authorized Representative complete the remainder of this form.

By signing this authorization, I acknowledge and agree that:

- If the box above is checked, the individual identified above who has been authorized to access my personal information will serve as my Authorized Representative in any and all matters pertaining to my account with Covered California.
- Once the individual listed above has been appointed to serve as my Authorized Representative, I further understand and acknowledge that he or she will have the authority to make decisions pertaining to my Covered California account, which could potentially affect my healthcare coverage.
- I authorize the disclosure or use of my personal information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information and to revoke my Authorized Representative's authority to act on my behalf at any time. Covered California will comply with my request within a reasonable period of time, however, I understand that any such withdrawal or revocation will not affect any information that was used or disclosed prior to withdrawal or revocation.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily.

Consumer Signature

By my signature below, I declare under penalty of perjury that the information on this form is true and correct.

Signature:	Date:

Authorized Representative Address Verification *(Please attached a copy of one of the following with your name and current address.)*		
California Driver's License ☐	Utility Bill ☐	Other ☐

Authorized Representative Identity Verification *(Please attached a copy of one of the following. If no identifying document is attached, your signature must be*	
California Driver's License ☐	State of California Identification Card ☐
Federal Issued I.D. Card ☐	Notary ☐
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

By signing this authorization, I acknowledge and agree that:

- I have been designated by the above-referenced consumer to serve as the Authorized Representative in any and all matters pertaining to his or her Covered California account and to make decisions which may affect the above-referenced consumer's healthcare coverage.
- I will at all times strictly maintain the confidentiality of the consumer's personal information and shall at no time disclose or use any such information for purposes not authorized by the consumer.
- I further agree to fully comply with any applicable federal or state laws pertaining to conflicts of interests and the confidentiality of the consumer's personal information.
- My Authorized Representative appointment will remain valid until the consumer notifies Covered California that I am no longer authorized to serve as his or her Authorized Representative or until I notify Covered California that I am no longer acting as the consumer's Authorized Representative.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily.

Authorized Representative Signature

By my signature below, I declare under penalty of perjury that the information on this form is true and correct.

Signature:	Date:

The information requested on this form is required by the California Health Benefit Exchange to process your request and will be used solely for this purpose. Failure to provide this information may result in the denial of your request. Legal references authorizing the collection or maintenance of the information provided on this form include Sections 1798.22, 1798.25, 1798.27 and 1798.35 of the California Civil Code and Section 155.260(a) of the Code of Federal Regulations. California Health Benefit Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.