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

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION BY AUTHORIZED REPRESENTATIVE

HBEX 404 (8/15)

Authorization for Release of Personal Information by a Parent, Guardian, or Authorized Representative

This form authorizes Covered California to release a consumer's personal information to the parties specified by the Authorized Representative. 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 the consumer's Covered California Account)*		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Account Number:		Date of Birth:

Parent, Guardian, or Authorized Representative's Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Daytime Phone Number *(Required)*	Email Address:	

What legal authority do you have to act on behalf of the Consumer? *(Please attached legal documentation.)*		
Parent ☐	Conservator ☐	Executor of Will ☐
Guardian ☐	Agent of Health Care ☐	Power of Attorney ☐
Other ☐		

Attached Copy of Representative's Identifying Information. *(If no identifying document is attached, your signature must be notarized.)*	
Driver's License ☐	State Identification Card ☐
Federal Issued Identification Card ☐	Notary ☐
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

Authorization		
I, _____, hereby authorize Covered California, to release the following information to the individual or entity identified below:		
Name of Individual or Entity:		
Street Address:	City/State:	Zip Code:
Day Time Phone Number:	Fax Number/Email Address:	
Purpose of Release:		

Authorized Representative's Signature	
I understand that by signing this authorization: • I authorize the use or disclosure of the Consumer's personal information as described above for the purpose listed. • I have the right to withdraw permission for the release of the Consumer's information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time and Covered California will comply with the request within a reasonable amount of time. The revocation must be made in writing and will not affect information that has already been used or disclosed. • I have the right to receive a copy of this authorization. • I am signing this authorization voluntarily.	
I understand Covered California may not be able to comply with my request but will provide me with a response. 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 Benefits Exchange, Privacy Office in order to process your request. The information you provide on this form is required to process your request and will be used by the Privacy Office for that 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 Benefits Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.	