

### AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name \_\_\_\_\_

ID Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize PUGET SOUND HEALTH PARTNERS to disclose the following information:

- Enrollment and eligibility information
- Medical records and diagnosis\*
- Psychotherapy notes\*
- Claims, claim status, and claim history\*
- Premium and billing information
- Other \_\_\_\_\_

PUGET SOUND HEALTH PARTNERS is authorized to disclose the information identified above to the following persons(s) and entity(ies):

Name _____	Name _____
Address _____	Address _____
Phone (     ) _____	Phone (     ) _____

The purpose of this disclosure is:  to assist me with my health plan  other \_\_\_\_\_

This authorization is valid for two years from the date of my signature or until: \_\_\_\_\_ (cannot exceed two years from date of signature)

I may cancel this authorization at any time by sending written notice to PUGET SOUND HEALTH PARTNERS, 32129 Weyerhaeuser Way S., Suite 201, Federal Way, WA 98001-9346. Cancellation of this authorization will not affect any actions taken by PUGET SOUND HEALTH PARTNERS authorized above before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. PUGET SOUND HEALTH PARTNERS' disclosure pursuant to this authorization is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that an authorized recipient may redisclose my information and the privacy protections provided by law may be lost.

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Signed \_\_\_\_\_ Dated \_\_\_\_\_

If this authorization is signed by a person acting on behalf of another person, please complete the following and attach documentation demonstrating your authority to act on behalf of another. This may include a Power of Attorney or Appointment of Representative form (Form CMS-1696).

_____ (     ) _____	_____
Name of Personal Representative	Phone Relationship

Signature of Personal Representative \_\_\_\_\_

\*Note: Information about claims, medical records, diagnosis, and psychotherapy may contain sensitive data, including data related to treatment of chemical dependency, sexually transmitted disease, HIV/AIDS, mental health, and reproduction or contraception. DO NOT check the boxes authorizing disclosure of claims, medical records, diagnosis, or psychotherapy notes if you do not want information relating to these sensitive conditions released.

Return form to:  
PUGET SOUND HEALTH PARTNERS, 32129 Weyerhaeuser Way S., Suite 201, Federal Way, WA 98001-9346