

We take great care to protect the information members entrust us with, and we do not release information without our members' written permission. Authorizations allow members or their legal representatives to give us permission to release their protected health information to another person(s) for a specific purpose. This allows us to meet our legal obligation to obtain written permission to release this information while still meeting your needs.

This guide is designed to help you complete this form. The items listed below must be present in any authorization received for personal information disclosure.

- 1) Your full name.
- 2) Your ID number (as it appears on your identification. or ID, card). If you are a member of more than one Regence health plan, please include all of your ID numbers.
- 3) The person(s) you would like to have your protected health information released to. Mailing address is optional; however, it is of assistance if the person(s) requests to have information sent to them. This authorization will remain valid even if this address changes in the next 24 months.
- 4) The purpose for which you are authorizing the person(s) to receive your protected health information. For example, "To assist me with my account" or "To handle my physical therapy claims."
- 5) We won't disclose protected health information regarding these listed conditions to the designated person(s) unless you initial each condition that you would like us to release this information about.
- 6) Your signature and the date.
- 7) The signature of your legal representative if they are completing the form on your behalf. Documentation showing such legal representation should be attached.

If you have additional questions regarding completing this form, please contact a customer service specialist at the phone number listed on the back of your health care plan ID card. Please note that a different authorization form is needed for psychotherapy notes.

Any alterations to the text of the authorization form will make it invalid.

Sincerely,

Regence BlueShield

**AUTHORIZATION FOR
USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**



**Regence
BlueShield**

An Independent Licensee of the Blue Cross
and Blue Shield Association

P.O. Box 21267
Seattle, Washington 98111-3267

Please print all information required.

I, _____, ID number, _____ authorize
(please print)

Regence BlueShield (my health plan) and/or my healthcare providers, including physicians and hospitals, to disclose my protected health information to (include name/address)

_____ for the purpose of
_____. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum information necessary to achieve the stated purpose.

My protected health information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinician office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I understand that my health plan needs my specific authorization to release information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

(Initial below)

Chemical dependency (includes alcohol/drug treatment)

Sexually transmitted diseases

HIV/AIDS

Genetic information

Mental health information (excludes psychotherapy notes)

Reproductive health (including abortion)

I may cancel this authorization at any time by sending a written request to Regence BlueShield at P.O. Box 21267, Seattle, Washington 98111-3267. My cancellation of this authorization will not affect any action my health plan took before it received my request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this contract and all claims arising from the contract have been settled, or 24 months from the date below, whichever comes first.

Federal law requires Regence BlueShield to tell me that, if the party to whom they disclose my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records that are protected by federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of this information without specific written authorization.

I understand that I am not legally obligated to sign this authorization and that if Regence BlueShield is unable to obtain information necessary to provide health benefits to me, my benefits may be denied.

SIGNATURE: _____ DATE: _____
(If signature by a personal representative of the member, please complete the following)

Personal representative's name: _____

Relationship to member: Parent Legal guardian* Holder of Power of Attorney*

*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney