



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I request and authorize the disclosure of protected health information for:

Member

Member Number

Social Security Number

Birth Date

To be released by Community Health Plan to:

Name

Relationship/Organization

Address

City/State/Zip Code

Phone Number

Fax Number

To be used for the purpose(s) of:

This request and authorization to disclose applies to:

All protected health information.

Protected health information relating to:

I understand that Community Health Plan (the "Health Plan") needs my specific authorization to release protected health information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

Sexually Transmitted Diseases (STDs) _____

HIV/AIDS _____

Alcohol and/or Chemical Dependency _____

Psychiatric Disorders/Mental Illness _____

Reproductive Health (including Abortion) _____

I understand that I may change my mind and revoke this authorization at any time by sending a written request to:

Community Health Plan
Attention: Customer Service Department
720 Olive Way, Suite 300
Seattle, WA 98101

I understand my change will not affect any action the Health Plan took before it received my request.

If I do not revoke this authorization, I understand that it will automatically expire upon termination of my coverage with the Health Plan, or

___ On _____, 20___, or

___ **No later than twenty four (24) months after the date it is signed.**

SIGNATURE: _____ **DATE:** _____

(If signature by a personal representative of the member, please complete the following)

Personal Representative's Name:

Relationship to member: Parent (for children 14 years of age or younger)
 Legal Guardian* Power of Attorney*

* Please attach legal documentation if you are the legal guardian or holder of a Power of Attorney.