



**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.