State Authorization to Release Health Care Information

COMMUNITY HEALTH PLAN of Washington™

This form is used to release your protected health information as required by state and federal privacy laws. Your authorization allows Community Health Plan of Washington to release your protected health information to a person or organization that you choose.

Member's Name: _____ Date of Birth: _____

Previous Name: _____ Member ID: _____

I request and authorize Community Health Plan of Washington to release health care information for the member named above to:

Name: _____ Date of Birth: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Documents or information to be released (check all that apply)

- ☐ All benefit claims or appeals
- ☐ Specific claims (specify date(s) of service, claim number, etc.)
- ☐ Billing/enrollment information
- ☐ Other (please specify):

Release of Health Care Information Authorizations

☐ Yes ☐ No — I authorize the release of my sexually transmitted disease* results, including HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that they may not further disclose these test results without first obtaining my specific written permission for such disclosure.

* Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

☐ Yes ☐ No — I authorize the release of any records regarding my reproductive health, including abortion related services, to the person(s) listed above.

☐ Yes ☐ No — I authorize the release of any records regarding my psychiatric disorder/mental illness related services to the person(s) listed above.

☐ Yes ☐ No — I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that I have the right to change my mind at any time and revoke this authorization by notifying Community Health Plan of Washington in writing. I also understand that any uses or disclosures already made with my permission cannot be taken back. I further understand that I may request a copy of this signed authorization.

Member Signature: _____ Date Signed: _____

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator for a member, you must complete the following and attach a copy of the legal documents evidencing this status.

Representative's Name: _____

Representative's Signature: _____ Date Signed: _____

Relationship to member:

☐ Parent (children 12 years of age or younger) ☐ Legal Guardian ☐ Power of Attorney

Expiration of Authorization

This authorization will expire (check only one):

☐ When I revoke this authorization

☐ Upon the following date, event, or condition:_____

Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.

I understand that I have the right to revoke this authorization earlier than the date/event set forth above. I understand that any revocation must be in writing and must include my name, address, telephone number, date of this authorization, and my signature and that I should send the revocation to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 521-8834

**** PLAN USE ONLY ****

This Authorization was revoked on: _____

Community Health Plan of Washington representative signature: _____

A full notice of your privacy rights is available upon request by calling Community Health Plan of Washington's Customer Service department at 1-800-440-1561. If you are hearing or speech impaired, please call TTY 7-1-1 (toll free).