Washington State Health Care Authority

Authorization for Release of Information

SECTION 1: **Health Care Authority is authorized to provide information or records regarding**:

Name: _____
Last name First name Middle initial

Address: _____

Phone (with area code): _____ Fax (with area code): _____

If this Release is for information pertaining to your dependent child(ren), name of dependent child(ren): _____

Person or organization authorized to receive information or records:

Name: _____

Address: _____

Phone: _____

I am enrolled in *(Please check one box)*:

☐ Basic Health ☐ Medical Assistance/SCHIP/MCS ☐ Public Employees Benefits Board (PEBB) Program ☐ Washington Health Program

Client I.D. Number or social security number: _____

Specific information to be used or disclosed (including dates if needed): _____

The following types of information must be specifically authorized. This authorization includes information about the following (check any that apply):

☐ Sexually transmitted disease ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Mental health ☐ Chemical dependency treatment

Reason for disclosure/purpose of disclosure: _____

This authorization will expire in 180 days or on: _____
Date or event

NOTICE to those receiving information: If these records contain information about HIV, STDs, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

SECTION 2: **Important Information About Your Rights**

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time prior to the expiration date or event noted above by telling the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility, and enrollment, or as allowed by law.
- The person or organization that I authorize to receive information about me or my dependent child(ren) might share it with another person or organization, and it might be not protected under the laws that apply to HCA.
- The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 (effective January 1, 2012, call 360-725-0442) or online at **www.hca.wa.gov**.

SECTION 3: **Signature**

_____ _____
Signature of enrollee or enrollee's representative *Date*
Form must be completed before signing.

_____ _____
Printed name of enrollee's representative *Relationship to enrollee*

Please return completed form to:
If Basic Health member—Health Care Authority, P.O. Box 42683, Olympia, WA 98504-2683
If Medicaid—Health Care Authority, P.O. Box 45509, Olympia WA 98504-5509, fax to 360-586-9323
If PEBB member—Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684 or fax to 360-923-2608 (effective January 1, 2012, fax to 360-586-2288)
If Washington Health Program member—Health Care Authority, PO Box 42714, Olympia, WA 98504-2714
If Subrogation—Health Care Authority, P.O. Box 45561, Olympia WA 98504-5561