

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name _____

ID Number _____ Date of Birth _____

I authorize Community Health Plan to disclose the following information:

- | | |
|---|---|
| <input type="checkbox"/> Enrollment and eligibility information | <input type="checkbox"/> Claims, claim status, and claim history* |
| <input type="checkbox"/> Medical records and diagnosis* | <input type="checkbox"/> Premium and billing information |
| <input type="checkbox"/> Psychotherapy notes* | <input type="checkbox"/> Other _____ |

Community Health Plan is authorized to disclose the information identified above to the following person(s) and entity(ies):

Name _____	Name _____
Address _____	Address _____
Phone () _____	Phone () _____

The purpose of this disclosure is: to assist me with my health plan
 other _____

This authorization is valid for two years from the date of my signature or until _____
(cannot exceed two years from date of signature)

I may cancel this authorization at any time by sending written notice to Community Health Plan, 720 Olive Way, Suite 300, Seattle, WA, 98101. Cancellation of this authorization will not affect any actions taken by Community Health Plan authorized above before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. Community Health Plan's disclosure pursuant to this authorization is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that an authorized recipient may redisclose my information and the privacy protections provided by law may be lost.

▶ _____
Signed

Dated

