AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name_____

Regence ID#_____ Date of Birth _____

I authorize Regence BlueShield to disclose the following information:

- ☐ Enrollment, eligibility, and benefit information
- ☐ Medical records and diagnosis*
- ☐ Psychotherapy notes*
- ☐ Claims, claim status, and claim history*
- ☐ Premium and billing information
- ☐ Other_____

Regence BlueShield is authorized to disclose the information identified above to the following person(s) or 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 Regence BlueShield, P.O. Box 1271, Portland, OR 97207-1271, MS-C7A, Portland, OR 97207-1271. Cancellation of this authorization will not affect any actions taken by Regence BlueShield before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment, or eligibility. Regence BlueShield 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

If this authorization is signed by a person acting on behalf of another person, please complete the following and attach documentation demonstrating your authority to act on behalf of another. (e.g., power of attorney, guardianship, conservatorship, etc.)

_____ (_____)_____ _____
Name of Personal Representative (please print) Phone Relationship

►_____
Signature of Personal Representative

*Note: Information about claims, medical records, diagnosis, and psychotherapy notes may contain sensitive data, including data related to treatment of chemical Dependency, sexually transmitted disease, HIV/AIDS, mental health, and reproduction or contraception. **DO NOT** check the boxes authorizing the disclosure of Claims, medical records, diagnosis, or psychotherapy notes if you do not want information relating to these sensitive conditions released.

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Please return completed form to Regence: P.O. Box 1271 MS-C7A, Portland, OR 97207-1271