AUTHORIZATION TO DISCLOSE

Instructions for completing this form:

PURPOSE
This Authorization to Disclose form is filled out when you (the Veteran, patient) want to grant another individual or organization access to your protected health information (PHI). Your PHI is protected by the Privacy Act, the Health Insurance Portability and Accountability Act (HIPAA), state laws, and TriWest policies and procedures.

IDENTIFICATION OF INDIVIDUAL OR ORGANIZATION
The information that you provide in the second section of this form tells TriWest to whom you want us to disclose your PHI. HIPAA allows TriWest to disclose your PHI to any provider, including the Department of Veterans Affairs (VA), who is involved in your care; therefore, **you do not need to provide this form for TriWest to share your PHI with VA or a provider who is involved in your health care.**

INFORMATION TO BE DISCLOSED
In this section of the form, you tell us what information you are authorizing TriWest to disclose to the individual or organization you have named. You may choose to disclose all of your PHI maintained by TriWest or, in a written description, you can specify the information you want disclosed to the designated individual or organization.

EXPIRATION
This Authorization to Disclose is valid for one year (12 months) from the date you sign if you do not enter a date in the space provided.

AGREEMENT
Your rights regarding this Authorization to Disclose form are outlined in the "Agreement" section of the form. Please read it thoroughly. You are required to sign the document in the "Signature" space provided. If you are unable to sign the document, please refer to the next paragraph regarding personal representatives.

PERSONAL REPRESENTATIVES
If you are having your Personal Representative prepare and sign this Authorization to Disclose form on your behalf, a copy of the Medical or Health Care Power of Attorney or other legal documentation appointing the individual as your Personal Representative must be attached to the form.

Please **mail** the completed and signed form to the following address:

Privacy Official

TriWest Healthcare Alliance

P.O. Box 42049

Phoenix, AZ 85080-2049

or

Fax to (602) 564-2523

Privacy Act Statement - This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations may be punishable by fines, imprisonment, or both.

AUTHORIZATION TO DISCLOSE

Please reference the Instructions page and complete all appropriate areas.

Whose protected health information (PHI) are you authorizing TriWest to disclose?
Name of **Veteran (First, Middle, Last)** _____
Veteran Contact Telephone (_____) _____
Veteran Choice Card Member ID Number _____, or **Veteran** SSN _____

Who are you authorizing TriWest to disclose your PHI to?
Note: This most likely will be a family member or friend. Per HIPAA, TriWest does not need authorization to share your PHI with a provider who is involved in your care.

I (Veteran) hereby authorize TriWest Healthcare Alliance and its business associates to disclose my PHI to:
Name of Individual/Organization _____
Relationship to Veteran _____
Address _____
City/Town _____ State _____ Zip _____
Contact Telephone (_____) _____ Fax number (If Available) (_____) _____
Email Address (If Available) _____

Information to be Disclosed (Check all that Apply):
Medical/Surgical Information _____ Claims Information _____ Mental Health/Substance Abuse Information _____
(*Does Not Include Psychotherapy Notes*)
Other (Please Specify): _____
_____

Date this Authorization is to Expire (mm/dd/yyyy)***: _____/_____/_____**
*****If no expiration date is entered, the expiration date will default to one year (12 months) from the date this form is signed. The maximum expiration date is fifty (50) years from date this form is signed.

Agreement: I understand that I may revoke this authorization at any time by submitting my revocation in writing to TriWest Healthcare Alliance, except to the extent that action has already been taken in connection with this authorization or that applicable law requires its disclosure. I am aware that the recipient named above may also further disclose my PHI according to his/her/their policies and practices and that my PHI may no longer be protected by HIPAA.

I further understand that TriWest Healthcare Alliance may not condition treatment, payment, enrollment or eligibility for benefits on my signed submission of this authorization. I am entitled to keep a copy of this form for my records.

_____ _____
Signature of Veteran Date

If the Veteran is unable to sign this form, the personal representative must sign below.

I am a personal representative of the above named Veteran and have attached proof of this relationship to this form (Medical or Health Care Power of Attorney [POA] or other legal documents, which state that I am authorized to have access to the Veteran's medical records).

_____
Signature of Veteran's Personal Representative

_____ _____
Print Name of Veteran's Personal Representative Date