QualChoice® ADVANTAGE

Authorization to Disclose Protected Health Information

Full Name _____ Phone _____

ID Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

I authorize QualChoice Advantage to disclose the following information:

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

QualChoice Advantage is authorized to disclose the information identified above to the following persons(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 QualChoice Advantage, PO Box 27510, Federal Way, WA 98093-4510. Cancellation of this authorization will not affect any actions taken by QualChoice Advantage authorized above before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. QualChoice Advantage'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

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. This may include a Power of Attorney or Appointment of Representative form (Form CMS-1696).

_____ ( ) _____ _____

Name of Personal Representative Phone Relationship

_____

Signature of Personal Representative

***Note: Information about claims, medical records, diagnosis, and psychotherapy 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 disclosure of claims, medical records, diagnosis, or psychotherapy notes if you do not want information relating to these sensitive conditions released.**

Return form to:

QualChoice Advantage, PO Box 27510, Federal Way, WA 98093

QualChoice Advantage is an HMO and PDP plan with a Medicare contract. Enrollment in QualChoice Advantage depends on contract renewal.