Authorization for Release of Protected Health Information Pursuant to HIPAA by WCIF, Affiliated Health Insurance Carriers, and Business Associates

WCIF
WASHINGTON COUNTIES INSURANCE FUND

Patient Name	Date of Birth	Social Security Number
Patient Address (street, city, state, zip)		Phone Number
Patient Email Address		

I hereby voluntarily authorize the use or disclosure of my protected health information as described below.

Unless revoked, this authorization will expire either a) within 90 days, or b) when my current issue is resolved (whichever is less).

Please read the following and initial below.

- I may revoke this authorization at any time prior to its expiration date shown below by notifying in writing the organization authorized to provide my protected health information (WCIF | PO Box 7786 | Olympia, WA | 98507 | 1-800-344-8570).
- If I revoke this authorization, I understand to revocation will not affect any uses or disclosures of my protected health information made by the providing organization before it received my revocation.
- I may see and copy the information described on this form if I request it (via either written or oral request).
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed because of this authorization may be re-disclosed by the organization receiving the information. If the information is re-disclosed, it may no longer be protected from being further used or disclosed without my authorization. I have the right to seek assurances from the organization I authorize to receive the information that they will not re-disclose the information to any other party without my further authorization.
- This form must be completed in its entirety before signing.

I have read and understand my rights regarding the privacy of my protected health information _____
Initials

Name and address of health provider or entity to release this information:

Name and address of person(s) or category of person to whom this information will be disclosed:

Specific information to be released:

☐ Health Information from (insert date) _____ to (insert date) _____

☐ Entire record of health information as kept by WCIF and affiliated health insurance carriers including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other health care providers.

☐ Billing and/or claims information.

☐ Other: _____
_____

_____ **Alcohol / Drug Treatment Information**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing Information**

Authorization to Discuss Health information

☐ By initialing here _____ I authorize _____
Initials — Name of individual / health care provider

to discuss my health information with my attorney, or a governmental agency listed here:

_____
Attorney / Firm name of Governmental Agency Name

Reason for release of information:

☐ At request of patient ☐ Other: _____

If not the patient, name of person signing form:	Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have retained a copy of this form.

_____ _____

Signature of patient or representative authorized by law
(Note: Form must be completed before signing.)
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Date *(Note: This authorization will expire the lesser of 90 days or the date upon which your current issue is resolved.)*