COMMUNITY HEALTH NETWORK of Washington™ | Cascade Select

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Community Health Network of Washington
Authorization to Disclose Protected Health Information

Use this form if you want Community Health Network of Washington (CHNW) to share your protected health information (PHI) with someone other than you.

1. **Enrollee Name:** _____ **Date of Birth:** _____

Enrollee ID Number: _____ **Date of Request:** _____

Enrollee Address: _____

Enrollee email: _____

Enrollee Phone: _____ **Enrollee Fax:** _____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. CHNW will only disclose the protected health information you want disclosed.

2A: Check only <u>one</u> box below to tell CHNW the specific protected health information you want disclosed:

☐ Limited Information (go to question 2B)

☐ Any Information (go to question 3)

2B: Complete <u>only</u> if you selected "limited information." Check all that apply:

☐ Information about your eligibility

☐ Information about your claims

☐ Information about premium payments

☐ Other (list the specific information you want released): _____

2C: Complete <u>only</u> if you wish to release protected health information related to protected diagnosis:

☐ Information about sexually transmitted disease (STD) testing and treatment, including HIV/AIDS testing and treatment (STDs include, but are not limited to, herpes, herpes simplex, genital warts, human papillomavirus, condyloma, chlamydia, syphilis, gonorrhea, etc.)

☐ Information about pregnancy tests, abortion services, prenatal care, and birth control

☐ Mental health information, including symptoms, diagnosis, medications, evaluations, and treatment plans

☐ Chemical dependency information, including symptoms, diagnosis, medications, and treatment plan (**Substance Use Disorder (SUD) information requires a signed written authorization**)

3. Check only one box below indicating when this authorization to disclose your protected health information will expire (subject to applicable law—for example, Washington State may limit how long CHNW may give out your protected health information):

☐ When I revoke this authorization

☐ Upon the following date, event, or condition: _____

4. Fill in the reason for the disclosure (you may write "at my request"):

_____

5. Fill in the name and address of the person or organization to whom you want CHNW to disclose your protected health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.

Name: _____

Address: _____

Name: _____

Address: _____

Note: you have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that CHNW has already acted based on your permission. To revoke authorization, send a

written request to the address noted below. Your authorization or refusal to authorize disclosure of your protected health information will have no effect on your enrollment, eligibility for benefits, or the amount CHNW pays for the health services you receive.

6. I authorize CHNW to disclose my protected health information listed above to the person(s) or organization(s) I have named on this form. I understand that my protected health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

_____ _____ _____
Printed Name Telephone Number Date

_____
Signature

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the enrollee signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the enrollee: _____

7. Send the completed, signed authorization to:

Community Health Network of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 652-7050
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHNW's Customer Service department at the following

Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8am to 5pm.

If you hare hearing or speech impaired, please call TTY 711 (toll-free).

The notice is also available online at: https://www.cascadeselect.org/member-center/member-rights/

**** PLAN USE ONLY ****

This authorization was revoked on: _____

CHNW representative signature: _____