

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name: _____

Regence ID# _____ Date of Birth _____

I authorize the following health care provider to disclose my health information, including medical records, chart notes, billing statements, hospital records, laboratory reports, records pertaining to mental health treatment, claims, and all other medical information, to The Regence Group and its affiliates:

Name of Provider _____

Address _____

Phone Number _____ Fax Number _____

The purpose of this disclosure is: to assist me with my health care.
 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 The Regence Group, Privacy Office, P.O. Box 1071, Mailstop E12B, Portland, OR 97207-1071. Cancellation of this authorization will not affect any actions taken prior to receiving my cancellation notice. My treatment, payment or eligibility may not be conditioned upon completing this authorization. The information disclosed pursuant to this authorization may be subject to Federal confidentiality rules published at 42 C.F.R. Part 2. Unless otherwise permitted by 45 C.F.R. Part 2, these rules prohibit the recipient of substance abuse information from further disclosing it without express consent. I acknowledge that certain disclosures are permitted by law and if permissible disclosures occur, federal law may no longer protect the privacy of this information.

Signed: _____ Dated: _____

If this authorization is signed by a person acting on behalf of another person, please complete the following and attach documentation demonstrating authority to act on behalf of another.

Name of Personal Representative Phone Number Relationship

Signature of Personal Representative Dated: _____