Authorization to Disclose Health Information

Notice to Member:

Completing this form will allow the plan to share your health information with the person or group that you choose.

- You do not have to sign this form or give permission to share your health information. Your services and benefits will not change if you do not sign this form.
- If you want to cancel this Authorization Form, fill out the Revocation Form on the next page. Mail it to us at the address below.
- Coordinated Care of Washington, Inc. can't promise that the person or group you choose will not share your information with someone else.
- Keep a copy of all forms that you send to us. The plan can send you copies if you need them.
- Fill in all information on this form. When finished, mail it to:

Coordinated Care Compliance Department
1145 Broadway, Suite 700
Tacoma, WA 98402

Member Information:

Member Name (print): _____

Member Date of Birth: ____/____/____ Member Apple Health (Medicaid) ID Number/Member ID#: _____

I give permission to share my health information with the person or group named below. The purpose of the authorization is to help me with my benefits and services.

Recipient Information:

Name (person/group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____- _____

Coordinated Care can share this Health Information: (check all boxes that apply)

☐ All of my health information; OR

☐ All of my health information EXCEPT:

- ☐ Prescription drug/medication information
- ☐ AIDS or HIV information
- ☐ Treatment for alcohol and/or substance abuse information
- ☐ Behavioral health services or psychiatric care information
- ☐ Other: _____

Authorization will end 1 year from date signed or until no longer a member of Coordinated Care, unless cancelled.

Member Signature: _____ **Date**: ____/____/_____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal delegate, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

If you have questions, need help to understand this form or need a different language or format, please contact: Member Services: 1-877-644-4613; Fax: 1-877-644-4602