**Authorization for Release of Information**

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| **SECTION 1: Health Care Authority is authorized to release information or records about** |
| Last name, First name, Middle initial | Client I.D. or Social Security number |
| Address | City | State | ZIP Code |
| Phone number ()  | If release is for information about dependent child(ren), name(s) of dependent child(ren) |
| **Reason/purpose for disclosure** | [ ]  At the request of the individual [ ]  Other:   |
| **Specific information to be used or disclosed (including dates, if needed; attach additional pages if more space needed)** |
| **The following types of information must be specifically authorized.** This authorization includes information about the following *(check all that apply)*:[ ]  Sexually transmitted diseases [ ]  Mental health[ ]  HIV/AIDS test results, diagnosis, or treatment [ ]  Chemical dependency treatment**Notice to those receiving information:** If these records contain information about HIV/AIDS, sexually transmitted diseases, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission from the person and meeting specific legal requirements. |
| **This authorization will expire in 180 days from the date signed below or on (give date or event)** |

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| **SECTION 2: Person or organization authorized to receive information or records** |
| Name | Phone number ()  |
| Address | City | State | ZIP Code |

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| **SECTION 3: Signature** |
| I have read and understand the following statements about my rights:* I may cancel this authorization at any time before the expiration date or event noted above by notifying the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
* I may see and copy the information described on this form if I ask for it.
* I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility and enrollment, or as allowed by law.
* The person or organization that I authorize to receive information about me or my dependent child(ren) might share it with another person or organization, and it might not be protected under the laws that apply to HCA.
* The Apple Health Notice of Privacy Practices and UMP Notice of Privacy Practices are available upon request by calling (844) 284-2149 or at [**www.hca.wa.gov/pages/privacy.aspx**.](http://www.hca.wa.gov/pages/privacy.aspx)
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| Signature of enrollee or enrollee’s representative DateForm must be completed before signing. If signed by representative provide power of attorney or proof of guardianship.Signature of child (if age 13 or older) representative DatePrinted name of enrollee’s representative Relationship to enrolleeProvide copy of power of attorney or guardian papers. |

**Please return completed form to:**

**If Washington Apple Health (Medicaid) or CHIP –** Health Care Authority, P.O. Box 45534, Olympia, WA 98504‐5509 or fax to 360‐507 9068

**If PEBB Program member** – Health Care Authority, P.O. Box 42684, Olympia, WA 98504‐2684 or fax to 360‐725‐0771

**If subrogation** – Health Care Authority, P.O. Box 45561, Olympia, WA 98504‐5561 or fax to 360-753-3077

**If request for disclosure of records** - Health Care Authority, P.O. Box 42704, Olympia, WA 98504-7204 or fax to 360-507-9068

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