**AUTHORIZATION FOR RELEASE OF**

**HEALTHCARE INFORMATION AND RECORDS**

**Please complete this form in its entirety to prevent a delay in processing. We will act on your request within 15 working days and will notify you in writing if additional information is needed.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Member Name: | | | |  | | | | | | | | | Date of Birth: | |  |
| (First/MI/Last) | | | | | | | | | | | | | | | |
| Subscriber Name: | | | | |  | | | | | Subscriber ID Number: | | | | |  |
| (First/MI/Last) | | | | | | | | | | | | | | | |
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| **HEALTHCARE INFORMATION AND RECORDS TO BE RELEASED TO:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Name: | |  | | | | | Phone: | | | | (   )     - | | | | |
|  | | | | | | | | | | | | | | | |
| Address: | | |  | | | Fax: | | (   )     - | | | | | | | |
|  | | | | | | | | | | | | | | | |
| City: |  | | | | | | State: | |  | | | ZIP: | |  | |
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| **INFORMATION TO BE RELEASED:**  I request and authorize the Federal Employee Program (the Plan) to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or healthcare provider, the information may no longer be protected by federal privacy regulations.  **General Health Care** - This includes claims, billing and eligibility information not related to sensitive information (see below) unless it is approved below.  **Sensitive** - I also approve the release of the following types of sensitive information by the Plan (check all boxes that apply to you)  All sensitive information  OR  Alcohol and/or Chemical Dependency  Genetic Information (genetic information is not collected or used for underwriting or enrollment purposes)  Psychiatric Disorders/Mental Illness  Reproductive Health (including abortion)  Sexually Transmitted Diseases (HIV/AIDS)  **Other**: | | | | | | | | | | | | | | | |
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| **PURPOSE FOR RELEASE:**  At the request of the Individual  OR  For this reason(s): | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **CANCELLING THIS RELEASE:** I may change my mind and cancel this authorization at any time by submitting my request in writing to the address located at the bottom of this form. After the Plan gets my notice, the Plan will cancel this release within five (5) business days. I understand that the Plan may already have shared some or all of my information and that the Plan will not be liable for any information already released.  **DURATION OF RELEASE:** This authorization will expire twenty four (24) months from the date signed unless a shorter time frame is requested here:  **NO CONDITION:** This authorization is voluntary. It does not affect the member’s enrollment in a health plan, eligibility for benefits, or payment of claims. | | | | | | | | | | | | | | | |
| **WHO MUST SIGN THIS FORM:**  **Washington Members**   * For a member age 12 or younger: the parent or legal guardian * For a member age 13 to 17, if no box, above, is checked other than “general health care”: the parent or legal guardian * For a member age 13 to 17, if any box, above, is checked other than “general health care”: the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian) * For a member age 18 or older: the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian)   **Alaska Members**   * For a member age 17 or younger: the parent or legal guardian * For a member age 18 or older: the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Member Signature or Designated Legal Representative/Guardian signature Date  **DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN:**  \*If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:  A copy of a health care, general or Durable Power of Attorney  OR  A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member’s behalf.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Legal representative (print full name) Legal relationship to member  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_  Legal representative street address City State ZIP code  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date | | | | | | | | | | | | | | | |

*When completed, send this form to:*

**Federal Employee Program**

**P.O. Box 91058**

**Seattle, WA 98111-9158**

**Fax: 877-202-3149**

**Please keep a copy of this request for your records.**

**Notice of Privacy Practices:**

Our Notice of Privacy Practices describes how we use and disclose member personal information and members’ rights concerning it. It can be found on the Federal Employee Program Service Benefit Plan website at ***www.fepblue.com***. For a paper copy, please call Customer Service at 800-562-1011.

