

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name _____

Regence ID# _____ Date of Birth _____

I authorize Regence BlueShield of Idaho and Regence Life and Health Insurance Company (Regence Life and Health) to disclose the following information:

- | | |
|---|---|
| <input type="checkbox"/> Enrollment and eligibility information | <input type="checkbox"/> Claims, claim status, and claim history* |
| <input type="checkbox"/> Medical records and diagnosis* | <input type="checkbox"/> Premium and billing information |
| <input type="checkbox"/> Psychotherapy notes* | <input type="checkbox"/> Other _____ |

Regence BlueShield of Idaho and Regence Life and Health are authorized to disclose the information identified above to the following person(s) or entity(ies):

Name _____ Name _____

Address _____ Address _____

Phone () _____ Phone () _____

The purpose of this disclosure is: to assist me with my health plan
 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 Regence BlueShield of Idaho or Regence Life and Health, P.O. Box 1271, MS-C7A, Portland, OR 97207-1271. Cancellation of this authorization will not affect any actions taken by Regence BlueShield of Idaho and Regence Life and Health Insurance Company before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. Regence BlueShield of Idaho and Regence Life and Health are not responsible for any action taken by an authorized recipient of my protected health information. I am aware that an authorized recipient may redisclose my information and the privacy protections provided by law may be lost.

▶ _____
Signed _____ Dated _____

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

Name of Personal Representative (please print) () Phone _____ Relationship _____

▶ _____
Signature of Personal Representative

* Note: Information about claims, medical records, diagnosis, and psychotherapy notes may contain sensitive data, including data related to treatment of chemical dependency, sexually transmitted disease, HIV/AIDS, mental health, and reproduction or contraception. **DO NOT** check the boxes authorizing the disclosure of claims, medical records, diagnosis, or psychotherapy notes if you do not want information relating to these sensitive conditions released.



Regence BlueShield of Idaho and Regence Life and Health Insurance Company are Independent Licensees of the Blue Cross and Blue Shield Association