AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Use this form to authorize USFHP* to use or disclose your protected health information.
All fields are required. Incomplete or incorrect forms will be returned.

US FAMILY HEALTH PLAN at PacMed

MEMBER INFORMATION

Member Name	Member ID#
Member Address	
Member City / State / Zip	
Member Date of Birth (MM / DD / YYYY)	Member Phone #

I hereby authorize USFHP to disclose the protected health information listed below to the following person / entity:

Name	Relationship to Member
Address / City / State / Zip	Phone Number
Email	

PERSONAL HEALTH INFORMATION TO BE DISCLOSED

What information can be disclosed? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Immunizations
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Sensitive Information. (Your initials are required to release the following information):

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

Describe the purpose for the disclosure. If all health information is to be released, then check only the first box.

- ☐ **All health / personal information**
- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

– CONTINUED ON OTHER SIDE –

Business Use Only. Family ID:

This authorization will remain in effect:

☐ From the date of this Authorization until the following date: _____

☐ For as long as necessary to complete the purposes of this Authorization: _____

☐ Until the following event occurs: _____

PLEASE NOTE

- You have a right to revoke this authorization in writing at any time and to send your written revocation to USFHP at the address listed below. Your revocation will not apply to information that USFHP has already disclosed in reliance on this Authorization.
- Information disclosed by USFHP in accordance with this request may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.
- Completion of this form will not affect the amount you pay, your eligibility for enrollment in the health plan, or your benefits.

SIGNATURE

I have read and understand the above information.
I certify that the signature below is my own and that I am legally authorized to sign this document.

Member, Parent, or Personal Representative* Signature	Date
Print Name	Relationship to Member, if signed by someone other than Member

* If not already provided, please attach legal documentation verifying personal representation. We will require verification of the authority of a Personal Representative before this request will be considered complete. (i.e. power of attorney, caregiver).

Please Return This Completed Form (and supporting documentation, if applicable) By Fax Or Mail:

Fax **206-621-4464**

Mail **US Family Health Plan**
Attn. Member Services
1200 12th Ave S
Seattle, WA 98144

If you have any questions about this Authorization Form, please contact a US Family Health Plan Member Services Representative at 800-585-5883, option 2.

US Family Health Plan at Pacific Medical Centers complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

中文 (Chinese)
Pacific Medical Centers 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-4PACMED（TTY：711）。

Tiếng Việt (Vietnamese)
Pacific Medical Centers tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi,
khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-4PACMED (TTY: 711).

Español (Spanish)
Pacific Medical Centers cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad
o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-4PACMED (TTY: 711).