Washington State Health Care Authority

Authorization for Release of Information

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 ( )			

Reason/purpose for disclosure ☐ At the request of the individual
☒ Other: **Application for Parenting Sentencing Alternative**

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
☒ HIV/AIDS test results, diagnosis, or treatment
☒ Mental health
☒ 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) **Release from Dept of Corrections**

SECTION 2: Person or organization authorized to receive information or records

Name DOC			Phone number ( )
Address	City	State	ZIP Code

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 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**.

Signature of enrollee or enrollee's representative — Date

Form must be completed before signing. If signed by representative provide power of attorney or proof of guardianship.

Printed name of enrollee's representative — Relationship to enrollee

Provide 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