Regence
Group Administrators
An Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FORM

Please return this form to Regence Group Administrators (RGA) by mail or fax:

Mail: RGA
Attn: Customer Care Team
PO Box 52890
Bellevue WA 98015

Fax: 1-866-458-5486

SECTION 1 – AUTHORIZATION INFORMATION	
Member Name:	Member ID Number:

I authorize RGA to disclose my health plan information to the following person:

Name: _____ Phone Number: (_____)_____

Mailing Address: _____

Email Address: _____

For: ☐ Assisting me with questions about or management of my health plan

☐ Other: _____

I have listed additional people on the back of this form: ☐ Yes ☐ No

Please note:

- Information will be disclosed only for the reason(s) listed above and will be limited to what is needed to respond to the request.
- Information may include claims payments, plan benefits, eligibility, and pre-authorization letters.

By initialing next to a condition below, I am authorizing release of information about me for that condition. (If you do not initial the following spaces, we will not release any information regarding that condition.)

_____ Chemical dependency, including alcohol and/or drug treatment

_____ HIV/AIDS

_____ Mental health information, not including psychotherapy notes

_____ Genetic testing

_____ Reproductive health, including abortion

_____ Sexually transmitted diseases

SECTION 2 – MEMBER SIGNATURE

I may cancel this authorization to disclose protected health information at any time by sending a written request to my group health plan or to RGA on behalf of my group health plan. My cancellation of this authorization will not affect any action my group health plan or RGA took before this request was received.

I understand that my authorization automatically expires when one of these events occurs:
1) I am no longer covered by this health plan.
2) All claims are settled.
3) 24 months have passed from the date of my signature below.

This authorization does not condition my treatment, payment, enrollment or eligibility for benefits.

Disclosure required by federal law: If the person I have authorized to receive my protected health information shares that information with anyone else, the information may no longer be protected by some state and federal laws. This excludes alcohol and drug abuse records that are protected by other federal confidentiality rules such as the Code of Federal Regulations (42 CFR Part 2).

_____ _____

(Signature) (Date)

If you are signing this form on a member's behalf, please complete the information below and attach documentation that verifies your status as an Authorized Personal Representative for the member.

_____ _____

(Authorized Personal Representative's Signature) (Date)

Print Name:	Phone Number: ( )
Relationship to Patient:	