

**AUTHORIZATION FOR RELEASE OF
HEALTH CARE INFORMATION AND RECORDS**



Member/Enrollee Name: _____ Date of Birth: _____
(First/MI/Last)

Subscriber Name: _____ Subscriber ID
(First/MI/Last) Number: _____

HEALTH CARE INFORMATION AND RECORDS TO BE RELEASED TO:

Name: _____ Phone: () _____
Address _____ Fax: () _____
City: _____ State: _____ ZIP: _____

TYPES OF INFORMATION TO BE RELEASED: I permit LifeWise Health Plan of Arizona, or any of its affiliates (the "Company"), to release the following health care information to the person/entity listed above. I understand that the Company needs my written authorization to release any health care information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS) or psychiatric disorders/mental illness. Based on the box(es) I have checked below, the Company may release all diagnostic, procedural, claim, prescription or other related information and records.

- General Health Care
- Sexually Transmitted Diseases (HIV/AIDS)
- Alcohol and/or Chemical Dependency
- Psychiatric Disorders/Mental Illness
- Reproductive Health (including abortion)
- Other: _____
- Genetic Information

PURPOSE FOR RELEASE AND HOW INFORMATION WILL BE USED:

- At the request of the Individual
- At the request of the Company for:
 - Research
 - Marketing
 - Other: _____
- Other (please state specific date, specific time period, event or condition): _____

REDISCLASURE: Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

TIMEFRAME OF RELEASE: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

*Signature: _____ Date: _____

Print Name: _____

*If not the member/enrollee, I am the Parent Legal Guardian Holder of Power of Attorney

If you are the legal guardian or holder of a power of attorney for the member/enrollee, please attach legal documentation.

REVOCAATION OF RELEASE: I understand that I may change my mind and revoke this release at any time. I will do this by letting the Company know of my decision. Any change will be effective five (5) business days after the Company receives my written notice at the address listed at the bottom of this form. I understand that some or all of this information may already have been shared and that the Company will not be liable for any information already released.

NO CONDITION: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

When completed, send this form to: LifeWise Health Plan of Arizona, P.O. Box 91102, Seattle, WA 98111-9202.

Please keep a copy of this request for your records.