Authorization to Disclose Instructions

This Authorization to Disclose form is filled out when you (the Beneficiary, member, patient) want to grant another individual or organization access to your protected health information (PHI). Your PHI is protected by the Privacy Act, the Health Insurance Portability and Accountability Act (HIPAA), state laws, and TriWest Healthcare Alliance (TriWest) policies and procedures.

If you have a Medical or Health Care Power of Attorney (POA) or other legal documents, which authorize a representative to have access to your medical records, you may provide the POA or legal documents and do not need to complete this form.

Identification of Individual or Organization

The information that you provide in the second section of this form tells TriWest to whom you want us to disclose your PHI. Per HIPAA, TriWest does NOT need authorization to share your PHI with a provider who is involved in your care.

Information to be Disclosed

In this section of the form, you tell us what information you are authorizing TriWest to disclose to the individual or organization you have named. You may choose to disclose your entire PHI maintained by TriWest or, in a written description, you can specify the information you want disclosed to the designated individual or organization.

Expiration

If you do not select one of the standard option periods or enter a date in the space provided, this Authorization to Disclose will be considered valid for one (1) year from the date you sign the form.

Agreement

Your rights regarding this Authorization to Disclose form are outlined in the “Agreement” section of the form. Please read it thoroughly. You are required to sign the document in the “Signature” space provided. If you are unable to sign the document, please refer to “Personal Representatives” below.

Personal Representatives

If you are a Personal Representative signing this Authorization to Disclose form on behalf of the beneficiary, a copy of the Medical or Health Care Power of Attorney or other legal documentation appointing you as the Personal Representative must be attached to the form. (See note regarding Medical or Health Care Power of Attorney above.)

Privacy Act Statement

This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations may be punishable by fines, imprisonment, or both.

Authorization to Disclose Form

If filling out manually, use blue or black ink to complete this form.

Beneficiary Information

First: Middle: Last:

Contact Phone:

DOD Benefits Number (DBN) or DOD ID Number:

Identification of Individual or Organization

Who is TriWest authorized to disclose your PHI to? (This is most likely a family member or friend.) Per HIPAA, TriWest does NOT need authorization to share your PHI with a provider who is involved in your care.

I (Beneficiary) hereby authorize TriWest and its business associates to disclose my PHI to the individuals listed below:

Name of Individual or Organization (#1):

Relationship to Beneficiary:

Address:

City: State: ZIP:

Name of Individual or Organization (#2):

Relationship to Beneficiary:

Address:

City: State: ZIP:

Name of Individual or Organization (#3):

Relationship to Beneficiary:

Address:

City: State: ZIP:

Authorization to Disclose Form

Information to be Disclosed

Check all that apply – if no boxes are checked, mental health will not be included:

- ☐ Medical and Claims Information
- ☐ Mental Health or Substance Abuse Information
- ☐ Scheduling of Appointments (does not include psychotherapy notes)
- ☐ Other (please specify): _____

Authorization Date: Day (DD)/Month (MM)/Year (YYYY): _____

Expiration

This authorization expires (check only one box below):

- ○ One year from date form is signed. (This is the default if no option is selected.)
- ○ Fifty (50) years from date form is signed.
- ○ Other date (Date cannot exceed 50 years from date form is signed. Please specify below.):

Expiration Date: Day (DD)/Month (MM)/Year (YYYY): _____

Agreement

I understand that I may revoke this authorization at any time by submitting my revocation in writing to TriWest, except to the extent that action has already been taken in connection with this authorization or that applicable law requires its disclosure. I am aware that the recipient named above may also further disclose my PHI according to his/her/their policies and practices and that my PHI may no longer be protected by HIPAA. I further understand that TriWest may not condition treatment, payment, enrollment or eligibility for benefits on my signed submission of this authorization. I am entitled to keep a copy of this form for my records.

Beneficiary Signature (If beneficiary is unable to sign, please see next section.):

_____

Agreement Date: Day (DD)/Month (MM)/Year (YYYY): _____

Authorization to Disclose Form

Personal Representative

The beneficiary is unable to sign this form. I am the beneficiary's Personal Representative and I have included one of the following documents, which authorizes me to sign this form and to have access to the beneficiary's medical records:

- ○ A Medical or Health Care Power of Attorney (POA)
- ○ Advanced Health Care Directives
- ○ Court Guardianship or Conservatorship papers
- ○ Other legal documents (please specify):

Beneficiary's Personal Representative Signature:

Printed Name of Beneficiary's Personal Representative:

Date: Day (DD)/Month (MM)/Year (YYYY):

Submit Form

Fax to 866-266-9820 or mail the completed and signed form to the following address:

Privacy Official
TriWest Healthcare Alliance
P.O. Box 42049
Phoenix, AZ 85080-2049