

# 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.

## MEMBER INFORMATION

Member Name	Member ID#	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> Patient Allergies        | <input type="checkbox"/> Radiology Reports & Images |
| <input type="checkbox"/> Physician's Orders     | <input type="checkbox"/> Discharge Summary        | <input type="checkbox"/> Lab Results                |
| <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Billing Information      | <input type="checkbox"/> Consultation Reports       |
| <input type="checkbox"/> Pathology Reports      | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> EKG/Cardiology Reports     |
| <input type="checkbox"/> Immunizations          | <input type="checkbox"/> Operation Reports        | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> History/Physical Exam  | <input type="checkbox"/> Diagnostic Test Reports  | _____   |

**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.

- |  |   |
|--|---|
| <input type="checkbox"/> All health/personal information   | <input type="checkbox"/> Legal Purposes           |
| <input type="checkbox"/> Treatment/Continuing Medical Care | <input type="checkbox"/> Disability Determination |
| <input type="checkbox"/> Personal Use                      | <input type="checkbox"/> School                   |
| <input type="checkbox"/> Billing or Claims                 | <input type="checkbox"/> Employment               |
| <input type="checkbox"/> Insurance                         | <input type="checkbox"/> 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 425-204-5636****Mail US Family Health Plan  
Attn. Enrollment  
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).