AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name_____

Regence ID#_____ Date of Birth (mm/dd/yyyy)_____

Group Number_____

Email Address_____

By providing your email address, you authorize us to use the email you have provided to confirm that this Authorization to Disclose Protected Health Information form has been implemented or to obtain any missing or necessary additional information to implement it.

If you have more than one Regence insurance policy, we will apply this authorization to all policies.

I authorize Regence to disclose the following information:

- ☐ Enrollment, eligibility, benefit information
- ☐ Medical records and diagnosis
- ☐ Alcohol/substance abuse*
- ☐ Pre-authorization
- ☐ Claims, claim status, and claim history
- ☐ Premium and billing information
- ☐ Appeals
- ☐ Other_____

This information may contain sensitive data, including data related to treatment of sexually transmitted diseases, HIV/AIDS, mental health, and reproduction or contraception (including prenatal care and abortion), gender dysphoria, gender affirming care, and domestic violence.

I authorize Regence to disclose the information identified above to the following person(s) or entity(ies):

First and Last Name	First and Last Name
Relationship	Relationship
Address	Address
(xxx) xxx-xxxx Phone	(xxx) xxx-xxxx Phone

You must choose one:
The purpose of this disclosure is: ☐ to assist me with my health plan **OR** ☐ other_____

This authorization is valid for two years from the date of my signature. I may cancel this authorization at any time by sending written notice to Regence, PO Box 1827, MS: B32M, Medford, OR 97501. Cancellation of this authorization will not affect any actions taken by Regence before receiving my cancellation notice. I understand completing this authorization is not a condition to receive treatment, payment, enrollment or eligibility. Regence is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that once Regence discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.

▶	(mm/dd/yyyy)
Signed	Date (mm/dd/yyyy)

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individual. (e.g., power of attorney, conservatorship, etc.).

	(xxx) xxx-xxxx	
Name of Personal Representative (please print)	Phone	Relationship
▶		(mm/dd/yyyy)
Signature of Personal Representative		Date (mm/dd/yyyy)

*Note: I understand that my substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described above.

Please Return completed form to Regence: PO Box 1827, MS: B32M, Medford, OR 97501
or email form to Government_Programs_Membership_Accounting_Fax_Repository@regence.com