

# AUTHORIZATION TO DISCLOSE TRICARE WEST REGION

## ABOUT THIS FORM AND WHO NEEDS TO COMPLETE IT

This Authorization to Disclose form is filled out when you, the beneficiary, 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 policies and procedures. The employees of TriWest Healthcare Alliance are trained to protect your information.

## IDENTIFICATION OF INDIVIDUAL OR ORGANIZATION

The information that you provide in the first section of this form tells TriWest to whom you want us to disclose your PHI. Should you need to grant access to your PHI to more than one individual or organization, please use a separate form for each.

## 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 all of your PHI maintained by TriWest or, in a written description, you can specify the information you want disclosed to the designated individual or organization.

## EXPIRATION

This Authorization to Disclose is valid for one year (12 months) from the date you sign, if you do not enter a date in the space provided.

## 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.

## PERSONAL REPRESENTATIVES

If you are having your "Personal Representative" prepare and sign this Authorization to Disclose form on your behalf, a copy of the Power of Attorney or other legal documentation appointing the individual as your "Personal Representative" must be attached to the form.

Please **mail** the completed and signed form to the following address:

WPS-TRICARE  
P.O. Box 77028  
Madison, WI 53707-1028

**or**

**Overnight** the completed and signed form to the following physical address:

WPS-TRICARE  
1707 W. Broadway  
Madison, WI 53707

**or**

You may fax your completed and signed form to:

(602) 564-2458.

***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 TRICARE WEST REGION

Please complete all appropriate areas on this form. Refer to other side for instructions.

I, (Name of **Beneficiary**) \_\_\_\_\_,

**Beneficiary** Contact Telephone (\_\_\_\_\_) \_\_\_\_\_

**Sponsor** Social Security Number \_\_\_\_\_, hereby authorize TriWest Healthcare Alliance and its business associates to disclose my Protected Health Information to:

Name of Individual/Organization \_\_\_\_\_ Relationship to Beneficiary \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax number (If Available) (\_\_\_\_\_) \_\_\_\_\_

E-mail Address (If Available) \_\_\_\_\_

### Information to be Disclosed (Check all that Apply):

Medical/Surgical Information \_\_\_\_\_ Claims Information \_\_\_\_\_ Mental Health/Substance Abuse Information \_\_\_\_\_  
*(Does Not Include Psychotherapy Notes)*

Other (Please Specify): \_\_\_\_\_  
\_\_\_\_\_

### The Purpose for Disclosing Your Protected Health Information (PHI)

To provide information at the request of the individual or organization named above.

To resolve a claims or payment issue.

Other (Please Specify): \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **If no expiration date is entered, the expiration date will be one year from the date this form is signed.**

**Agreement:** I understand that I may revoke this authorization at any time by submitting my revocation in writing to TriWest Healthcare Alliance, 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 protected health information (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.

\_\_\_\_\_  
Signature of Beneficiary/Requestor

\_\_\_\_\_  
Date

**I am a personal representative of the above named Beneficiary and have attached proof of this relationship to this form (Power of Attorney [POA] or other legal documents).**

\_\_\_\_\_  
Signature of Beneficiary's Personal Representative

\_\_\_\_\_  
Date