AUTHORIZATION TO DISCLOSE

Instructions for completing this form:

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.

PURPOSE
This Authorization to Disclose form is filled out when you (the Veteran, 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 policies and procedures.

IDENTIFICATION OF INDIVIDUAL OR ORGANIZATION
The information that you provide in the second section of this form tells TriWest Healthcare Alliance Corp. ("TriWest") to whom you want us to disclose your PHI. HIPAA allows TriWest to disclose your PHI to any provider, including the Department of Veterans Affairs (VA), who is involved in your care; therefore, **you do not need to provide this form for TriWest to share your PHI with VA or a provider who is involved in your health 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
This Authorization to Disclose is valid for one (1) year 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. If you are unable to sign the document, please refer to the next paragraph regarding personal representatives.

PERSONAL REPRESENTATIVES
If you are a Personal Representative signing this Authorization to Disclose form on behalf of the Veteran, 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 POA before the purpose statement above.

Please **Fax** to (602) 564-2523

or

Mail the completed and signed form to the following address:
(you do not need to send this instruction page to TriWest)

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

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.

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Fax to (602)564-2523 or mail to address on the instruction page.

Name of **Veteran (First, Middle, Last)** _____
Veteran Contact Telephone (_____) _____
Veteran Choice Card Member ID Number _____, or **Veteran** SSN _____

Whom are you authorizing TriWest to disclose your PHI to? **(This most likely will be 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 (Veteran) hereby authorize TriWest and its business associates to disclose my PHI to:
Name of Individual(s) _____
Relationship to Veteran _____
Address _____
City/Town_____ State _____ Zip _____ Contact Telephone (____) _____

Information to be Disclosed (Select all that Apply):
If no boxes are selected, information disclosed will not include Mental Health or Substance Abuse)

☐ Medical and Claims Information
☐ Scheduling of Appointments
☐ Other (Please Specify): _____
☐ Mental Health or Substance Abuse Information **(*Does Not Include Psychotherapy Notes*)**

Date This Authorization is to Expire (Select only one box)**:**

☐ 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 (mm/dd/yyyy): _____/_____/_____ **(**Cannot exceed 50 years from date form is signed.)

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.

_____ _____
Signature of Veteran Date

☐ ***The Veteran is unable to sign this form.***
As the Veteran's Personal Representative, I have included one of the following documents, which authorizes me to sign this form and to have access to the Veteran's medical records.
Note: You must provide at least one of the following documents or this form cannot be processed.

- ☐ ***A Medical or Health Care Power of Attorney (POA)***
- ☐ ***Advanced Health Care Directives***
- ☐ ***Court Guardianship or Conservatorship papers***
- ☐ ***Other legal documents***

_____
Signature of Veteran's Personal Representative

_____ _____
Print Name of Veteran's Personal Representative Date