AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name ______________________________

Regence ID# ______________________________ Date of Birth ______________

I authorize Regence BlueCross BlueShield of Oregon and Regence Life and Health Insurance Company to disclose the following information:

- ☐ Enrollment and eligibility information
- ☐ Medical records and diagnosis*
- ☐ Psychotherapy notes*
- ☐ Claims, claim status, and claim history*
- ☐ Premium and billing information
- ☐ Other ______________________

Regence BlueCross BlueShield of Oregon and Regence Life and Health Insurance Company are authorized to disclose the information identified above to the following person(s) or entity(ies):

Name **RECORDS DEPOSITION SERVICE, INC.**

Address **PO BOX 5054, SOUTHFIELD, MI 48086-5054**

Phone **(248) 357-3330** Fax **(248) 357-3337**

Name ______________________

Address ______________________

Phone ( ) ______________________

The purpose of this disclosure is: ☐ to assist me with my health plan

☒ other **FOR DISCOVERY BEFORE TRIAL**

This authorization is valid for two years from the date of my signature or until ______________________ (cannot exceed two years from date of signature).

I may cancel this authorization at any time by sending written notice to The Regence Group, P.O. Box 1271, MS-C7A, Portland, OR 97207-1272. Cancellation of this authorization will not affect any actions taken by the entities authorized above before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. The entities disclosing information pursuant to this authorization are not responsible for any action taken by an authorized recipient of my protected health information. I am aware that an authorized recipient may redisclose my information and the privacy protections provided by law may be lost.

______________________________ Signed

______________ Dated

If this authorization is signed by a person acting on behalf of another person, please complete the following and attach documentation demonstrating your authority to act on behalf of another.

______________________ Name of Personal Representative (please print)

( ) ______________ Phone

______________ Relationship

______________________________ Signature of Personal Representative

* Note: Information about claims, medical records, diagnosis, and psychotherapy notes may contain sensitive data, including data related to treatment of chemical dependency, sexually transmitted disease, HIV/AIDS, mental health, and reproduction or contraception. **DO NOT** check the boxes authorizing the disclosure of claims, medical records, diagnosis, or psychotherapy notes if you do not want information relating to these sensitive conditions released.

Independent Licensees of the Blue Cross and Blue Shield Association

Return form to: Regence, P.O. Box 1271 MS-C7A, Portland OR 97207-1271.

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