Authorization for the Release of Protected Health Information ("PHI")
**SOUND HEALTH AND WELLNESS TRUST "Plan"**

Submit form to:
**Fax:** 7022160885, **or Mail**: Privacy Officer, 11724 NE 195th St, Ste 300, Bothell, WA 98011

**This form authorizes the release of PHI by: *Zenith American Solutions, the third-party administrator for the Plan.***

*THIS FORM IS VOLUNTARY–SUBMIT ONLY IF YOU WANT TO AUTHORIZE A PERSON/ORGNIZATION ACCESS TO YOUR INFORMATION.*

***PLEASE CAREFULLY READ THE DIRECTIONS AND PRINT CLEARLY. ANSWER ALL APPLICABLE QUESTIONS.***

## 1) Employee/Participant

| Last Name | First Name | Date of Birth (mm/dd/yy) | Last 4 digits of SSN # or Member ID # | Phone |
|---|---|---|---|---|
| | | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

## 2) Individual whose PHI is to be released, **required only if it's the spouse or dependent's information to be released.**

| Individual's Full Name (only one individual permitted per Authorization) | Relationship to Employee | Date of Birth (mm/dd/yy) | Phone |
|---|---|---|---|
| | | | |

## 3) Person or organization (or class of persons/organizations) authorized to receive the PHI

Name: _____ Relationship *(e.g., spouse, lawyer, etc.)*: _____

## 4) Describe the PHI to be used or disclosed

☐ Any/All Information **OR**

☐ Claims ☐ Eligibility ☐ Appeals ☐ Payment-Related (Include dates, if applicable) _____

☐ Other (specify): _____

## 5) Indicate the specific purpose of the Authorization

☐ At my request **OR** ☐ for a different purpose (specify): _____

## 6) This Authorization will expire (choose one)

☐ When I revoke it in writing **OR** ☐ On this date OR event: _____

**Important Information About Your Rights -** I have read and understand the following statements about my rights:

- This authorization is voluntary, and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the Privacy Officer at the address at the top of the form. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receive treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

## 7) Signature of Individual or Personal Representative* making the request

**By signing below, I am authorizing the release of the information stated in this Authorization.**

**I am:** ☐ the Employee ☐ Adult Dependent or Spouse ☐ Parent/Guardian* ☐ Legally Authorized*

| **Print Name** | **Signature** | **Date** |
|---|---|---|
| | | |
| Address/Phone, *if different from Employee*: | Address | Phone |

***PERSONAL REPRESENTATIVE -** A *personal representative* is someone who has authority under applicable law to act on someone's behalf, such as a parent or guardian of a minor child, or an attorney-in-fact designted by a Durable Power of Attorney "POA". If the covered parent signs the Authorization on behalf of their dependent minor, legal documentation is not required. Documentation is required if signing pursuant to a legal designation; please submit a copy of such legal documentation *(e.g. a POA, designation of Guardianship or Estate Trustee).*

# Instructions for Completion of

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("PHI") FORM

All sections on the form require a response. Please print legibly. Failure to complete all sections will result in denial of the request and return of the form for correction.

**<u>THIS FORM IS VOLUNTARY</u> – Complete only if you want to authorize another person or organization to have access to your information.**

1. **Employee/Participant** – **REQUIRED**: Provide information about the account holder/ employee/participant. We require this information to locate the individual in our systems.

2. **Individual whose information is to be released – required only if it's the spouse or dependent's information to be released.**: Whose information is to be shared? If it is the employee/participant, leave blank. If it is a dependent (spouse, adult, or minor child), provide their information. *Only one individual is permitted per Authorization.*

3. **Person or organization (or class of persons/organizations) authorized to receive the information – REQUIRED**: This is the person or organization to whom you are permitting the plan to release protected health information. *(Examples: John Doe, spouse; XYZ Law Firm)*

4. **Describe the information to be used or disclosed – REQUIRED**: Check *"Any and All"* **or** specify what type of information can be released. *(Examples: claims information from 2020-2025; eligibility and billing information, etc.)*

5. **Indicate the purpose of the Authorization – REQUIRED:** You may check *"At my request"* or write your own purpose. *(Examples: "To discuss benefits with the Trust Fund so I can better understand my benefits", or "My spouse helps me with my EOBs and bills.")*

6. **This Authorization will expire (choose one) – REQUIRED:** Include a specific date or event for which you want the Authorization to expire. Check *"Until I revoke in writing"* **or** write in a specific date or event *(Example: "Upon termination of enrollment in the health plan"*).

7. **Signature of Individual or Personal Representative* making the request – REQUIRED:** Check the appropriate box to indicate who is signing the form. The Authorization must be signed and dated:

    - By the individual whose information is being released **if the individual whose information is being released is of legal age in their state of residence, <u>or</u>**
    - By the individual's Personal Representative If the Authorization is being signed *on the individual's behalf.*
        - A *personal representative* is someone who has authority under applicable law to act on someone's behalf, such as a parent, guardian, or durable power of attorney. <u>Please submit a copy of such legal document, if applicable</u> *(for example, a Power of Attorney, Guardianship documentation)*.
        - If the participant is signing the Authorization on behalf of their dependent minor, legal documentation is not required.