

## Member Requested Authorization for Release of Information

### Member Information (Person granting release of information)

Member Name \_\_\_\_\_

Member ID \_\_\_\_\_

Date of Birth \_\_\_\_\_

I authorize CMS(Claims Management Services) and Pierce County to release the following information (Check all that apply)

\_\_\_\_\_ Address, date of birth, membership status

\_\_\_\_\_ Benefits

\_\_\_\_\_ Claims

\_\_\_\_\_ Psychotherapy Notes

\_\_\_\_\_ Premium Information

\_\_\_\_\_ Other Please Specify \_\_\_\_\_

### CMS and Pierce County may release this information to:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

#### Purpose for this Release

\_\_\_\_\_ Request of Member or Personal Representative

\_\_\_\_\_ Other Please Specify \_\_\_\_\_

If the information relates to diagnosis or treatment of alcoholism or drug dependency, we must have the name of the treatment facilities or program(s):

If the information relates to diagnosis or treatment of alcoholism or drug dependency I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me.

For all information other than diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

### Right to Revoke

I understand that I may cancel this Authorization in writing at any time, but it will not affect any release of any information processed before I cancel it.

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here: \_\_\_\_\_

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or other Personal Representative

\_\_\_\_\_  
Date

If this request is by a personal representative on behalf of the Member, complete the following: Personal Representative's Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**Note:** You have a right to keep a copy of this notice after you sign it.