WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355

AUTHORIZATION TO RELEASE PRIVATE INFORMATION

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), I authorize the use/disclosure of my protected health information to the entity/person listed below and/or their authorized agent for purpose(s) listed below. I agree that by my signature below such information may be communicated under the Protected Health Information Rule* and may be used for audit or statistical purposes. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

I authorize the following people/organization to use/disclose my protected health information (please initial beside each person/organization): _____

_____

_____

_____

The following people/organization may receive my protected health information (please initial beside each person/organization):_____

_____

_____

_____

<u>THIS REQUEST/AUTHORIZATION APPLIES TO:</u>

Please describe in detail the information to be used or disclosed:

_____

_____

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WCLIB #25-A