# Authorization to Release Protected Health Information (PHI)

**I. Individual** (Name and information of person whose protected health information is being disclosed):

Name _____ Date of Birth _____

Group # _____ Identification/Subscriber # _____ Social Security # _____

Address _____ City _____ State _____ ZIP _____

**II. Authorization and Purpose**:

I request and authorize FirstCare/Southwest Life and Health Insurance Company (SWLH) to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy laws.

Persons/Organizations authorized to receive your information _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Purpose of this disclosure _____

**III. Specific Description of Information to be Used or Disclosed** (Complete A and B)

A. Release of Sensitive Protected Health Information Under State Law ☐ YES ☐ NO

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to:

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases)
- Drug, alcohol or substance abuse
- Mental health or developmental disabilities
- Genetic testing

B. Release of Protected Health Information (Claims, Benefit Information, Service Determinations, Premiums)

Date From _____ Date To _____

*This Authorization CANNOT be used to disclose Psychotherapy Notes

**IV. Expiration and Revocation**

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event) _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

**V. Signature** (this document must be signed by the individual, parent of minor child or the individual's personal representative)

**(a)** I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Custodian of Records, FirstCare/SWLH, 1901 W. Loop 289, Suite 9, Lubbock TX, 79407. I understand that such a revocation is not retroactively effective.

**(b)** I understand that information used or disclosed pursuant to this authorization TO AN INDIVIDUAL of my choosing may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

**(c)** I understand that if FirstCare/SWLH was the entity requesting this authorization to disclose Protected Health Information, it will obtain a confidentiality agreement with the party to whom the protected health information is being shared. However, it is still possible that the information will be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

**(d)** I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (see FirstCare/SWLH's "Notice of Privacy Practices").
- Refuse to sign this authorization (in which case no action will be taken and no records will be disclosed).

**(e)** I also understand that FirstCare/SWLH has the right to object to sharing of my Protected Health Information with the individual I've indicated, and that if FirstCare/SWLH does object, it will provide a reason in writing, and I may then appeal the rejection by contacting the Custodian of Records at 800-884-4901 or the Office of Civil Rights at the location shown on the FirstCare/SWLH "Notice of Privacy Practices".

_____

Signature of Member (or Personal Representative, if applicable)

_____

Date

_____

Description of Personal Representative's Authority (if applicable)

**If you have any questions about this form, please call customer service at (800) 884-4901**

**Return form to:**
**FirstCare Health Plans/Southwest Life and Health Insurance Company**
**1901 W. Loop 289, Suite 9**
**Lubbock, TX 79407**
**Attention: Custodian of Records**
**or fax form to: (806) 784-4190**