AUTHORIZATION

FOR USE OR DISCLOSURE OF HEALTH INFORMATION

William C. Earhart Co., Inc., Attn: H&W Privacy Office, P O Box 4148, Portland, OR 97208
Telephone: (503) 282-5581 Fax: (503) 284-9386

PURPOSE OF AUTHORIZATION

This Authorization is required for your health plan to release your health information to someone other than yourself or for purposes outside the health plan's normal functions of treatment, payment or healthcare operations. On behalf of your health plan, Northwest Administrators, Inc. will rely on it to disclose health information of the individual listed immediately below. Please review it carefully.

INFORMATION ABOUT INDIVIDUAL WHOSE HEALTH INFORMATION WILL BE DISCLOSED

Please provide information about yourself (or the "individual" whose protected health information will be disclosed if you are a personal representative such as a parent, legal guardian or person with power of attorney.)

Individual's Name:______________________________ Birth Date:______ /______/ ______
MM DD YR

Address:______________________________ Daytime Telephone No.:

______________________________ ______________________________

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INFORMATION ABOUT THE COVERED PARTICIPANT

Participant's Name: ______________________________

Last 4 digits of Participant's Social Security Number: ______________________________

NATURE OF DISCLOSURE BEING AUTHORIZED

The information requested in Questions 1 through 4 must be provided for this Authorization to be effective.

1. **Describe Information To Be Disclosed**
   Identify here what you authorize to be used or disclosed. The information you are requesting to be released must be specific such as "Information related to knee surgery." You cannot request that all health information be disclosed for all health conditions. ______________________________

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2. **Identify Who You are Authorizing to Receive the Information**
   List the name and address of the person you are authorizing to receive your health information. Remember the information being disclosed is your private health information.

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3. **Expiration Date of Authorization**
   Provide the date when this Authorization will end. Unless otherwise indicated, this authorization will expire one year from the date received by Northwest Administrators.

   Expiration date: ______________________________

4. **Signature and Date**
   By signing this Authorization, I authorize Northwest Administrators, Inc. on behalf of my health plan, to release my health information for the purpose stated above.

   Signature:______________________________ Date: ____________________

   If the person signing this Authorization is a Personal Representative of the individual to whom the health information relates, please complete the following.

   Personal Representative Name: ______________________________

   Relationship to the Individual: ______________________________

   If Personal Representative is someone other than a parent, **please attach a copy of the legal documentation creating your authority to act for the named individual** (e.g., executed health care power of attorney, legal guardian).

RETURN COMPLETED FORM TO:

William C. Earhart Co., Inc.
Attn: H&W Privacy Office
P O Box 4148
Portland, OR 97208

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STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION

General Rights. I understand I am not required to sign this form and that the Health Plan receiving it cannot condition treatment, payment or eligibility on my decision to sign this form. I understand, however, that a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make an eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

Right to Revoke. I understand that I have the right to revoke this authorization except as to uses and/or disclosures already made in reliance on it. I understand that I may revoke this authorization by sending a written request to:

William C. Earhart Co., Inc.
Attn: H&W Privacy Office
P O Box 4148
Portland, OR 97208

Effect of Disclosure. I understand that if the person(s) to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e. are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

Retention and Right to Copy. I understand that the Health Plan that receives this Authorization must retain a copy and that I am entitled to receive a signed copy upon request.

Provisions Related to Psychotherapy Notes. I understand that an Authorization is required for any use or disclosure of psychotherapy notes except in the limited situations dealing with treatment, training or defense of legal actions as defined in 45 CFR 164.508(a)(2).

PERSONAL REPRESENTATIVE

The health plan, for purposes of the Privacy Rule will treat a properly designated personal representative as the individual for purposes of the Privacy Rule. This will apply when the individual is deceased; the personal representative has been designated in accordance with applicable law, or in the case of unemancipated minors, a parent to the extent allowed by applicable law. The health plan reserves the right to decline to recognize an individual as a personal representative if there is a reasonable belief that the individual whose information would be disclosed has been or could be subject to abuse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law. A statement concerning disclosure of information regarding minors is available from the Privacy Officer.

PLEASE KEEP A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS