COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE

The power of community

# Permission to Verbally Discuss Protected Health Information

Member Name:_____Date of Birth: _____

I give permission for Community Health Plan of Washington (CHPW) to **verbally** discuss the information about me marked below (check all that apply):

- ☐ Medical information, including symptoms, diagnosis, medications, and treatment plans.
- ☐ Information about sexually transmitted disease (STD) testing and treatment, including HIV/AIDs testing and treatment.
- ☐ Information about pregnancy tests, abortions services, prenatal care, and birth control.
- ☐ Mental health information, including symptoms, diagnosis, medications, evaluations and treatment plans.
- ☐ Chemical dependency information, including symptoms, diagnosis, medications, and treatment plan. **Substance Use Disorder information may require a signed written authorization.**
- ☐ Educational history and evaluations, including Individualized Educational Plans.
- ☐ Referrals for services requested and/or recommended by my providers, including appointment information.
- ☐ Other:_____

CHPW may discuss the above information with:

| Name | Phone Number | Entity/Relationship to Member |
|---|---|---|
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| | | |

I understand that I do not have to sign this form. The information will be shared to help coordinate my health care. I understand this form may be used to discuss information related to my health care. Any release of substance use disorder information must be in accordance with 42 CFR Part 2. **I understand if I do not sign this form, then CHPW will not be able to discuss my information with the people listed on this form.**

I understand I may cancel this permission at any time (by writing to CHPW). Cancelling it will not impact any information that has already been discussed. **This form is valid until I cancel it or one year after it is signed.**

| | | |
|---|---|---|
| Signature of member 13 years of age or older/guardian | Date | Relationship to member |
| Witness if member is unable to sign | Date | Reason member is unable to sign |

If signed by authorized representative, attach copies of supporting legal documentation.

***Note: A minor member's signature is REQUIRED to share information about: 1. STD/HIV/AIDs, pregnancy, abortion, prenatal care, and birth control 2. Mental health treatment 3. Substance abuse treatment.***

# Permission to Verbally Discuss Protected Health Information

CHPW must follow privacy laws that impact sharing your health information. We want to make it easy for you to have family, friends, and others you designate involved in your care. You can use this form to list people who you want us to talk with about your medical care.

**How can I give someone permission to verbally discuss about me?**
Fill out the *Permission to Verbally Discuss Protected Health Information* form on the other side of this page to let us know who we can talk to. Check the boxes to tell us what information we may discuss.

**How is the information on the form used?**
We use this form to make sure we have permission to discuss your health information with people who may be involved in your care.

**What are some examples of when this might be useful?**

- An elderly parent wants an adult child to help with medical care
- A friend is helping an elderly patient with health issues
- A college student wants information shared with a parent
- An adult child calls to find out a parents appointment time

**Can the person I list on this form get copies of my medical records?**
No, this form only gives CHPW permission to verbally discuss information. If you want us to share your medical records you must complete an Authorization to Release Protected Health Information. This form is on the CHPW website at https://www.chpw.org/for-members/your-privacy-and-rights/

**What if I change my mind?**
You can cancel or change this permission form at any time by sending us a written statement.

**What happens if I don't complete this form?**
We will not discuss your protected health information except as allowed by law.

**What are the rules for minor members?**
A minor member can receive certain services without parental consent. In these instances the minor must sign this form to allow us to discuss their information.

**Where do I send the completed form or any changes?**
***Community Health Plan of Washington***
1111 Third Avenue, Suite 400
Seattle, WA 98101
***Fax: (206) 652-7088***