COMMUNITY HEALTH PLAN of Washington™
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Authorization to Disclose Health Information Packet for Electronic Application Access

Use this packet to authorize someone other than you (like a caretaker, or relative) the ability e to access your health information, through a third-party application. You must complete and return to Community Health Plan of Washington (CHPW) **BOTH** forms.

Return form to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: CustomerCare@chpw.org

Any representative you authorize to access your health information through a third-party app will have access to **all** your information. You will not be able to limit access to information you do not want shared. This includes treatment for substance use disorders, mental health, HIV status, or other sensitive information.

Interoperability

CHPW is required to create a secure, standards-based **Patient Access Application Programming Interface (API)** that allows members to easily access their health information through third-party apps of their choice. This is known as "interoperability."

Interoperability means that you can retrieve and share health information securely with people you authorize. You can use a third-party app to access your health information to better understand and manage your own health care.

For more information on how to protect your health information and considerations for selecting an application, visit our Member Education Page here: https://www.chpw.org/member-center/member-rights/using-third-party-apps/

Your Rights under the Health Insurance Portability and Accountability Act (HIPAA) and Who Must Follow HIPAA

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces the HIPAA Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule. HIPAA applies to covered entities (health plans such as CHPW, providers (primary care physician, facilities)). You can find more information and FAQs about your rights under HIPAA here: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

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Are third-party apps covered by HIPAA?

Because third-party apps are not covered entities, HIPAA rules do not apply. Instead they fall under the jurisdiction of the Federal Trade Commission (FTC) and the FTC Act. The FTC Act protects against deceptive acts (e.g., shares personal data without permission). For more information about mobile app privacy and security click here: https://www.consumer.ftc.gov/articles/0018-understanding-mobile-apps.

Filing a complaint

If you believe your rights under HIPAA have been violated, you can file a complaint with CHPW by contacting our Customer Service department at 1-800-440-1561, or by completing a Privacy/Security Incident Report and returning it to CHPW. The Privacy/Security Incident Report can be found here.

You can also file a complaint with OCR through their Complaint Portal. Learn more about filing a complaint with OCR under HIPAA.

If you believe a third-party app has inappropriately used, disclosed, or sold your information, you may file a complaint with the FTC using the FTC Complaint Assistant.

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Community Health Plan of Washington
Authorization to Disclose Protected Health Information
For Third-Party Application Access

Use this form if you want Community Health Plan of Washington (CHPW) to share your protected health information (PHI) with someone other than you through a third-party application.

For more information on how to protect your health information and considerations for selecting an application, visit our Member Education Page here: https://www.chpw.org/member-center/member-rights/using-third-party-apps/

1. **Member Name:** _____ **Date of Birth:** _____

Member ID Number: _____ **Date of Request:** _____

Member Address: _____

Member email: _____

Member Phone: _____ **Member Fax:** _____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. Be aware, if authorized **ALL** the information listed below will be shared with your representative through the third-party application.

- Information about your eligibility
- Information about your claims
- Information about premium payments
- Information about sexually transmitted disease (STD) testing and treatment, including HIV/AIDS testing and treatment (STDs include, but are not limited to, herpes, herpes simplex, genital warts, human papillomavirus, condyloma, chlamydia, syphilis, gonorrhea, etc.)
- Information about pregnancy tests, abortion 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 (SUD) information requires a signed written authorization**)

3. Check only one box below indicating when this authorization to disclose your protected health information will expire (subject to applicable law—Washington State may limit how long CHPW may give out your protected health information):

☐ When I revoke this authorization

☐ Upon the following date, event, or condition: _____

4. Fill in the reason for the disclosure (you may write "at my request"):

_____

5. Fill in the name and address of the person(s) to whom you want CHPW to disclose your protected health information. If you would like to authorize any additional individuals, please add those to the back of this form.

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Note: you have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that CHPW has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your protected health information will have no effect on your enrollment, eligibility for benefits, or the amount CHPW pays for the health services you receive.

6. I authorize CHPW to disclose my protected health information to the person(s) I have named on this form. I understand that my protected health information may be re-disclosed by the person(s) and may no longer be protected by law.

_____	_____	_____
Printed Name	Telephone Number	Date

_____
Signature

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the member: _____

7. Send the completed, signed authorization to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

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If you are a Washington Apple Health (Medicaid) Member Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8:00 a.m. to 5:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/for-members/your-privacy-and-rights/	**If you are a CHPW Medicare Advantage Member** Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8:00 a.m. to 8:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://medicare.chpw.org/member-center/member-rights/
If you are a Cascade Select Member Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8:00 a.m. to 5:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/for-members/your-privacy-and-rights/	

**** PLAN USE ONLY ****

This authorization was revoked on: _____

CHPW representative signature: _____

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Community Health Plan of Washington
Authorization to Release Confidential Substance Use Disorder Treatment Information
For Third-Party Application Access

Use this form if you want Community Health Plan of Washington (CHPW) to share your protected substance use disorder (SUD) treatment (alcohol or drug treatment) information (Part 2 Protected Records) with someone other than you through a third-party application.

1. **Member Name:** _____ **Date of Birth:** _____

Member ID Number: _____ **Date of Request:** _____

Member Address: _____

Member email: _____

Member Phone: _____ **Member Fax:** _____

If parent/guardian consent is for information about inpatient SUD treatment of a minor, please list the minor's name:

_____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. The above-named member hereby authorizes CHPW to disclose information concerning the member's name and other personal identifying information, their status as a patient obtaining diagnosis, treatment, and referral for treatment with a Part 2 Program, and medications to the below person(s):

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Name: _____

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Address: _____

Phone: _____ Date of Birth: _____

3. Be aware, if authorized ALL the information listed below will be shared with your representative through the third-party application:

- All benefit claims data related to SUD treatment
- Appeals
- Billing and Enrollment information
- Records related to my SUD treatment at a Part 2 Program

4. The purpose of the disclosure herein is to: _____

5. I understand that my Part 2 Protected Records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time (verbally or in writing) to the extent that action has been taken in reliance on it, and that **in any event his consent expires automatically as follows** (specify date, event or condition upon which consent expires):

_____

_____ _____ _____

Member Printed Name **Member Phone** **Date**

_____

Member Signature

5a. Signature of parent or guardian for dependent minor member's Part 2 Protected **inpatient** SUD treatment records:

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian Phone** **Date**

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_____
Parent/Guardian Signature

☐ Check here if you are signing as a personal representative (person authorized to sign in lieu of member) and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the member: _____

7. Send the completed, signed request to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

If you are a Washington Apple Health (Medicaid) Member	**If you are a CHPW Medicare Advantage Member**
Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, 8am to 5pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/for-members/your-privacy-and-rights/	Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, 8am to 8pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://medicare.chpw.org/member-center/member-rights/

If you are a Cascade Select Member Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8:00 a.m. to 5:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/for-members/your-privacy-and-rights/	