SOUTHWEST WASHINGTON MEDICAL CENTER EMPLOYEE HEALTH PLAN
Prior Authorization and Case Management Services administered by Columbia United Providers
19120 SE 34th St Suite 201, Vancouver, Washington 98683
TEL (888)944-7926 FAX (360) 449-8949

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Member:_______________________________________Date of Birth:___________________

I hereby authorize the use or disclosure of my protected health information to:

____

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Please provide a specific description of protected health information that may be used/disclosed:

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The protected health information will be used/disclosed for the following purpose(s):

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CONDITIONS:

- I understand that this authorization is voluntary and that I may refuse to sign this authorization.
- I understand that I am authorizing the above named individuals/organization to access my confidential health care information only for the purpose listed above.
- I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.
- I understand that I may revoke this authorization at any time by notifying Columbia United Providers in writing.
- I understand that I have a right to receive a copy of this authorization, if requested by me.

This authorization is in effect from ________________to__________________(length of time). Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted beyond that date.

SIGNATURES:

Member name printed:____Date:______________________

Member Signature:____Date:______________________