

Authorization for Release of Psychotherapy Notes

Instructions:

Use this form to authorize us to release your psychotherapy notes (that we maintain) to the person or entity you name. We would not normally give your information to this person/entity.

In this form, you must complete all sections and specify:

- the person or entity you want to receive a copy of your psychotherapy notes
- the purpose of this authorization.

Note: We do not usually get or keep copies of your psychotherapy notes. In most cases, you will need to contact your mental health provider directly.

This authorization will remain valid for 24 months, or until you notify us in writing to cancel it.

For details on your rights regarding your personal information that we maintain, see our Notice of Privacy Practices. You can find it on our Web site at student.lifewiseac.com, or call Customer Service at the number on the back of your ID card to receive a paper copy.

**AUTHORIZATION FOR RELEASE OF
PSYCHOTHERAPY NOTES**



Member Name: _____ Date of Birth: _____
(First/MI/Last)

Subscriber Name: _____ ID Number: _____
(First/MI/Last)

HEALTH CARE INFORMATION AND RECORDS TO BE RELEASED TO:

Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

City: _____ State: _____ Zip: _____

TYPES OF INFORMATION TO BE RELEASED: I permit LifeWise Assurance Company, and any of its affiliates (the "Company"), to release Psychotherapy Notes Only to the person/entity listed above. I understand that the Company needs my written authorization to release these records.

PURPOSE FOR RELEASE AND HOW INFORMATION WILL BE USED:

- At the request of the Individual
- Other (please state specific date, specific time period, event or condition):

REDISCLASURE: Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

EXPIRATION OF RELEASE: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below or at the end of the research event if checked above.

*Signature: _____ Date: _____

Print Name: _____

*If not the member/enrollee, I am the Parent Legal Guardian Holder of Power of Attorney

If you are the legal guardian or holder of a power of attorney for the member/enrollee, attach legal documentation.

REVOCAION OF RELEASE: I understand that I may change my mind and revoke this release at any time. I will do this by letting the Company know of my decision. Any change will be effective five (5) business days after the Company receives my written notice at the address listed at the bottom of this form. I understand that some or all of this information may already have been shared and that the Company will not be liable for any information already released.

You have the right to refuse to sign this Authorization. Your refusal to sign this Authorization will not affect your enrollment in a health plan or eligibility for health benefits.

Please keep a copy of this release for your records.

Send this form completed to:
LifeWise Assurance Company, P.O. Box 91102, Seattle, WA 98111-9202

Discrimination is Against the Law

LifeWise Assurance Company (LifeWise) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator – Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-971-1491 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-971-1491 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-971-1491 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-971-1491 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-971-1491 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-971-1491 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-971-1491 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-971-1491 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-971-1491 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-971-1491 (TTY: 711).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-971-1491 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-971-1491 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 800-971-1491 (TTY: 711).

ໂປດອຸບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີຮັບໃຫ້ທ່ານ. ໂທ 800-971-1491 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-971-1491 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-971-1491 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-971-1491 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-971-1491 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-971-1491 (TTY: 711).

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-971-1491 (TTY: 711) تماس بگیرید.