

## Authorization for Release of Psychotherapy Notes

Fill out this form to let us share notes that a mental health provider made during counseling or therapy sessions. The provider keeps these notes as a record of treatment and progress. Without this release, we would not share these notes, in most cases.

### Instructions

**Note:** You may have to call the mental health provider to get copies of psychotherapy notes. We do not usually get or keep copies of them.

Make sure to tell us:

- whom you want to receive a copy of the psychotherapy notes
- how these notes are to be used

If you have questions about this form, please call Customer Service at 800-971-1491 (TTY: 711).

### Notice of Privacy Practices

Our Notice of Privacy Practices describes how we may use and disclose member personal information and members' rights concerning it. This notice is on our website at [www.Lifewiseac.com](http://www.Lifewiseac.com). If you need a paper copy, call Customer Service at 800-971-1491 (TTY: 711).



## Authorization for Release of Psychotherapy Notes

Please fill out all the information below. **Print clearly.** Make a copy for your records and mail the completed form to:

LifeWise Assurance Company  
P.O. Box 91102  
Seattle, WA 98111

### MEMBER INFORMATION

Member name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First name / Middle initial/ Last name Month Day Year

Subscriber name: \_\_\_\_\_  
First name / Middle initial/ Last name

Subscriber ID number: \_\_\_\_\_

### YOUR INFORMATION (if not the member)

**Important:** If you are not the member, you must be the member’s parent, legal guardian, or holder of Power of Attorney (POA). If you are the legal guardian or holder of POA, please send legal proof with this form.

Your name: \_\_\_\_\_  
First name Middle initial Last name

Your relationship to the member:  Parent\*  Legal guardian  Holder of POA

### MAILING ADDRESS (Release Psychotherapy Notes to)

Tell us to whom and where you want us to release the Psychotherapy notes to for this member:

Send to (check one):  Member  Parent, legal guardian, or holder of POA  Another Person

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ ZIP: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_

### TYPE OF INFORMATION YOU ARE REQUESTING

**INFORMATION TO RELEASE:** I allow LifeWise and its affiliates (the “Company”) to release psychotherapy notes only to the person or organization that I listed, above. I understand that the Company needs my written authorization to release these records.

REASON FOR RELEASE:

At the member's request

Other (Please state the specific date, time period and event or condition: for example, a research study): \_\_\_\_\_

**WHO MUST SIGN THIS FORM?**

- For a member age 12 or younger: the parent or legal guardian
- \*For a member age 13 or older: the member or POA (unless a court has appointed a legal guardian)

**SIGNATURE**

By signing my name, below, I understand and agree to the following:

**CANCELLING THIS AUTHORIZATION:** I may change my mind and cancel this release at any time by writing the Company. After the Company gets my written notice, the Company will cancel this release within five (5) business days. During these five days, the Company may have shared some or all of my information. The Company is not liable for this information.

**SHARING THIS INFORMATION:** The person or organization that receives these notes may be able to share them. State and federal privacy rules may no longer protect them.

**DURATION OF RELEASE:** This release lasts for twenty-four (24) months from the signature date, below, or as stated, above, under "Reason for Release," unless I write to cancel it.

**RIGHT OF REFUSAL:** I have the right NOT to sign this authorization. My refusal to sign this form will not affect the member's enrollment in a health plan or eligibility for health benefits.

Sign your name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Print your name: \_\_\_\_\_

## Discrimination is Against the Law

LifeWise Assurance Company (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. 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, sex, gender identity, or sexual orientation, 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](mailto: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>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

## 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:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ 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 ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711)።

**XIYYEEFFANNAA:** 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:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສ່ຽງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-971-1491 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sévis 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).

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