Authorization for Use and Disclosure

Fax to BPA Health at 208-344-7430
Contact BPA Health at (800) 922-3406

Client Name _____ Date of Birth_____

I understand that Protected Health Information (PHI) about me is information that may identify me and relates to my past, present or future physical or mental health or condition and related health care services. I authorize the use and disclosure of PHI about me as described below.

The persons (or class of persons) authorized to receive the information:

_____

Description of the information that may be used and disclosed:

_____

_____

_____

My PHI may be used and disclosed by BPA Health for the following purposes:

_____

_____

_____

This authorization will expire upon the following date or event:

_____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that BPA Health may not condition treatment, payment, enrollment or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

I also understand that pursuant to BPA Health's Notice of Privacy Practices, I may revoke this authorization at any time except to the extent that action may have been taken in reliance on this authorization. I further understand that to revoke the authorization I must deliver notice, in writing, to BPA Health's Privacy Officer at the following address.

BPA Health
Attn: Privacy Officer
380 E Parkcenter Blvd, Suite 300
Boise, ID 83706

To receive a copy of this form, complete the address information below:

Name: _____
Address: _____
City, State & Zip: _____

Further, I understand that if the person or entity that receives the information is not a person or entity covered by privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.

This authorization will remain in effect until it expires or BPA Health receives written revocation.

_____ _____

Signature of Client or Personal Representative Date

_____

Printed Name of Client or Personal Representative

Legal Personal Representative's relationship to client and basis for authority to sign on behalf of the client (e.g., Power of Attorney, Legal Guardianship, etc.):

This form must be approved and signed by a BPA Health representative before any PHI is released. This occurs after this form is completed by the client or personal representative.

_____ _____

BPA Health Representative Date