HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PRIVACY ACT STATEMENT

PRIVACY ACT STATEMENT: In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191: E.O. 9397 (SSAN): DoD 6025, 18-R.
PRINCIPAL PURPOSE(S): This form is used to authorize the TRICARE West contractor to disclose protected health information.
ROUTINE USES: To any third party of the individual upon authorization for the disclosure from the individual for: personal use, insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information. This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse program.

Right to cancel (revoke): You may revoke this authorization at any time, but it cannot be made retroactive. The TRICARE West contractor may act in reliance on this authorization until a revocation request is processed or until the expiration date identified below.

Please submit the completed request to:

Incomplete and/or unsigned forms will not be processed.

TRICARE Legal Documents
PO Box 8818
Virginia Beach, VA 23450-8818
FAX: 1-844-308-8877

TRICARE BENEFICIARY INFORMATION

Last Name	First Name	Date of Birth (mm/dd/yyyy)

Sponsor Social Security Number (SSN)	OR	Beneficiary DoD Benefits Number (DBN)

PERMISSION YOU ARE GRANTING

I give the TRICARE West contractor/Health Net Federal Services, LLC permission to share my health information by phone or correspondence with the person or group named below (excludes alcohol or drug/substance abuse information).

LIMITED AUTHORIZATION (OPTIONAL — MAY BE LEFT BLANK)

I limit this permission to share only the following information, episode of care, or type of care:

AUTHORIZATION DATES

This authorization is considered effective the date it is signed and supersedes authorizations or limitations previously submitted. It will expire on 12/31/2029 unless indicated below:

Expiration date _____ (mm/dd/yyyy) (enter a specific date – "indefinite" or "forever" are not acceptable)

PERSON OR ENTITY YOU ARE AUTHORIZING TO RECEIVE YOUR INFORMATION

Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ ZIP: _____

IF SIGNING AS PARENT OF MINOR CHILD OR LEGAL REPRESENTATIVE: If a representative, include appropriate legal documentation.

Last Name: _____ First Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ ZIP: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of Attorney ☐ Executor ☐ Other

Signature: _____ **Date:** _____ (mm/dd/yyyy)

(beneficiary, parent or legal representative)