Attached is the authorization to disclose personal health information form you requested. You may take back "revoke" your written permission at any time. You may revoke authorization in writing to the address noted below or by calling member services.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information.

Acceptable documentation:

- Executor/Executrix papers
- Next of Kin attested by court documents with a court stamp and a judge signature
- Letter of Testamentary or Administration with a court stamp and judge signature
- Personal representative paper with court stamp and judge signature

Where to return your completed authorization form:

Health Choice Pathway HMO D-SNP
410 N. 44th Street Suite 900
Phoenix, AZ 85008

Please call Health Choice Pathway at **1-800-656-8991** if you have any questions. TTY users should call **711**. We are open seven days a week, from 8 a.m. to 8 p.m.

Thank you for your continued membership in Health Choice Pathway.

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Health Choice Pathway will only disclose the personal health information you want disclosed. Use this form if you want Health Choice Pathway to give your personal health information to someone other than you.

First Name:	Middle Initial:	Last name:	Birth Date:

Member Number:	Home Phone Number: ( )

Check only **one** box below indicating how long Health Choice Pathway can use this authorization to disclose your personal health information.

☐ Disclose my personal information indefinitely

☐ Disclose my personal information for a specified period only

Beginning: _____ (mm/dd/yyyy) Ending: _____ (mm/dd/yyyy)

Personal Representative: _____

Birth Date: _____

Address: _____

Phone number: _____

Relationship to Member: _____

☐ Check here if you are signing as a personal representative. Please attach the appropriate documentation which indicates your authority to make a request for information, for example legal power of attorney.

I understand that by signing this form I authorize Health Choice Pathway to disclose my personal health information to the person(s) I have named on this form.

Your Signature*: _____ Date: _____