OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Authorization for release of information

**Indicates a required field*

*I _____ (Medicare beneficiary or representative's
Please print clearly
name), hereby authorize _____ (SHIBA staff or
Please print clearly
volunteer advisor's name) to obtain records and related information about:

_____

_____

*1. State problem/issue

This release includes medical, business, financial records and other related information. The purpose for the release of this information is:

_____

_____

(***Note:*** *State purpose, such as to assist with a medical billing or coverage question, to help enroll in or use a Medicare health and/or drug plan, help get an insurance claim paid, or to request help applying for benefits (i.e., Extra Help.*)

*2. Release of medical information by other entities

I authorize any insurance company, health service contractor, health maintenance organization, or medical and dental providers, that has any record of, or knowledge about the insured named on this form, to provide that information to the Washington State Office of the Insurance Commissioner. They may share copies of any records or any other information, including medical records and claim files. A photocopy of this complaint form authorization is as valid as the original.

***Medicare beneficiary or representative signature:**

_____

Date: ___/____/_____

Nature of representation (parent, guardian, power of attorney, etc.)**:**

_____

NOTE: This authorization expires six (6) months from the date on which it was signed.