



Group Health Cooperative
Health Plan Administration
AOC North Building
12401 East Marginal Way South
Tukwila, WA 98168

www.ghc.org

Clear Care Sound Consent Form for Release of Health Care Information

Full Name (include middle initial): _____

Group Health ID #: _____

Date of Birth: ____ / ____ / _____

Daytime Telephone #: ____ - ____ - _____

This form is an authorization to release health care information for the purpose of verifying a qualifying medical condition for Group Health's Clear Care® Sound special needs plan. To be a member of this plan, you must have one of the following conditions: congestive heart failure (CHF), coronary artery disease (CAD), or diabetes. Medicare regulations require that Group Health verify a qualifying medical condition (1) when you first enroll onto the special needs plan, and (2) subsequently if needed to verify continuing eligibility. Disenrollment from Clear Care Sound revokes this authorization.

I hereby request and authorize the release of health care information to Group Health for the purpose of determining eligibility for the Clear Care Sound special needs plan:

Your Signature*: _____ **Date:** ____ / ____ / ____

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this release of information form and 2) documentation of this authority is available upon request by Group Health or by the health care provider.

<p>If you are the authorized representative, you must provide the following information:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: ____ - ____ - _____</p> <p>Relationship to Enrollee: _____</p>
