E.S. v. Regence BlueShield
For more information, visit: www.WAHearingAidSettlement.com.
Questions? Email info@WAHearingAidSettlement.com or call 1-877-706-9538 (Toll-Free) or 1-877-721-6680 (TTY).

Authorization for the Release and/or Discussion of Protected Health Information (ROI)

First Name | MI | Last Name

Unique ID:

Authorization

1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. **Epiq, the Notice and Claims Processor for the *E.S. v. Regence BlueShield* Settlement**
10300 SW Allen Blvd
Beaverton, OR 97005
503-350-5800

3. to release and/or discuss personal information, including contact information and other personal health information such as complete record, outpatient care, inpatient care, x-ray results, laboratory results, treatment plans, or any other available records necessary to perfect a claim for the *E.S. v. Regence BlueShield* Settlement

4. to **Class Counsel, Sirianni Youtz Spoonemore Hamburger PLLC.**
3101 Western Avenue #350
Seattle, WA 98121
206-223-0303

Class Counsel may assist the Settlement Class Members in curing any problems with the Settlement Class Member's claim via communication with, or through, the Notice and Claims Processor or with the Settlement Class Member directly.

This information release is a request for the purpose of legal assistance.

5. I have carefully read and understand the above information and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or organizations named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires one year from today's date, or upon revocation.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signature of Patient — Date: MM – DD – YYYY

Print Name of Patient

Signature of Parent, Guardian, or Legal Representative (if necessary) — Date: MM – DD – YYYY

Print Name of Parent, Guardian, or Legal Representative (if necessary)

Please return this document to the Notice and Claims Processor:
Email: info@WAHearingAidSettlement.com
Mail: *E.S. v. Regence BlueShield* Settlement Claims Processing
P.O. Box 2287
Portland, OR 97208-2287