OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Medical release form

Please complete and sign this form to release medical information.

I authorize any medical provider/facility, insurance company, health service contractor, health maintenance organization, or Multiple Welfare Arrangement 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 medical release form authorization is as valid as the original.

Print full name: _____

Insured or representative signature: _____

Date: ____/____/_____

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

To read our confidentiality statement go to: www.insurance.wa.gov/complaint-confidentiality-statement

After you complete this form, send it to us using one of the following methods:

Upload online
www.insurance.wa.gov and sign in to your account

U.S. Postal Service
Washington State Office fo the Insurance Commissioner
PO BOX 40255
Olympia WA 98504-0255

FAX
360-586-2018

Questions?

Call our Insurance Consumer Hotline

1-800-562-6900

www.insurance.wa.gov