AUTHORIZATION TO RELEASE CONFIDENTIAL AND ACCOUNT INFORMATION

Name: _____ Date of Birth: _____

HPF Application ID _____

I request and authorize Washington Health Benefit Exchange to disclose and provide copies of any and all information concerning my Healthplanfinder account to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

These records include, but are not limited to: personal, financial and customer service records.

I understand that this authorization is only good for this specific request and another requests will require another signed release.

I have read and understand the nature of this authorization.

_____ _____

Signature of Customer Date

_____ _____

Signature of Designated Representative Date