{MergeDateTime}

{MEM_FIRST_NAME} {MEM_MID_INIT} {MEM_LAST_NAME} Click here to enter text.
{MEM_ADDR1}
{MEM_ADDR2}
{MEM_ADDR3}
{MEM_CITY} {MEM_STATE} {MEM_ZIP}

Member ID#: {Sub_ID}{Mem_Sfx}
Group Name: {Group_Name}

Dear {Mem_First_Name} {Mem_Last_Name}:

Enclosed is the release of information consent form you requested. Please complete the entire form, sign it and return it to Providence Health Plan. You may send your release of information consent form to Providence Health Plan at:

Providence Health Plan
Attn: Customer Service
PO Box 4327
Portland Oregon 97208-4327

You may fax your release of information consent form to 503-574-8731 or 1-800-425-0199 or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
Attn: Customer Service
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

Please Note: The enclosed consent form must be completed, signed and dated.

If you have any questions or concerns, you may contact your Customer Service Team at 503-574-7500 or 1-800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1-888-244-6642. Customer Service representatives are available Monday through Friday, between 8 a.m. and 5 p.m.

Sincerely,

Providence Health Plan
Enclosure

MEMBER AUTHORIZATION FORM

By completing the Member Authorization form, you are telling Providence Health Plan (PHP) that you chose the named person in Part B below and this form allows PHP to disclose your Protected Health Information (PHI) and Personally Identifiable Information (PII) to the person you choose.

Part A. Information about the member whose healthcare information will be disclosed.

Part B. Name of the person or company you are authorizing to receive your PHI/PII.

Part C. The reason for your authorization? For the personal use of the member, for a specific reason or event or for a legal purpose.

Part D. Tell us what information may be disclosed.

All Information: Check if authorizing "all PHI" as listed to be shared with the person or company listed in PART B except for Sensitive Health Information

Or

Only the information specified: Check each item you are authorizing.

Part E. Tell us what sensitive information may be disclosed.

Sensitive Health Information: Please note that you will need to place your initials next to the Sensitive Information if you wish to authorize release of this information. **Please note:** The signature of a minor is required to authorize release of Sensitive Health Information to their parent or legal guardian in order for Providence Health Plan to disclose this information. (To authorize the release, the minor must sign the form along with the parent/ guardian to be valid.)

Part F. You may allow the person in PART B to perform administrative functions on your behalf.

Part G. Date your Authorization Expires

Part H. You have the right to revoke your authorization and you understand what you have authorized.

PART I. Your Approval (signature & date)

Use this form to authorize Providence Health Plan to use or to disclose your health information to another person or company. The Authorization Form must be completed in full for it to be valid. Please complete the following information exactly as it appears on your member identification (ID) card.

PART A: MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number (See your member ID card)**	**Group Number (See your member ID card)**
Member Home/Street Address	**City and State, Zip Code**	**Preferred phone #:**

PART B: PERSON OR COMPANY WHO WILL RECEIVE YOUR INFORMATION

The following person(s), facility or company have the right to receive my protected health/personal information. (They must be 18 years of age or older). Please fill in the below:

Recipient's Name: _____

Relationship to Member: _____
(Spouse/Domestic Partner/Friend/Caretaker/Broker/Other)

PART C: THE REASON FOR MY AUTHORIZATION (check one):

☐ Personal Use
☐ Only for this reason/event(s):
_____

(Only applies for a specific reason or event, an example might be to settle a claim or a one-time release)

☐ Legal Purpose

PART D: INFORMATION THAT CAN BE RELEASED BY PROVIDENCE HEALTH PLAN

I allow the following information to be disclosed by Providence Health Plan on my behalf to the person in PART B.

☐ **All Information (as listed to the right)**:

Check if authorizing all PHI to be shared with the person or company listed in Part B above except for Sensitive Health Information. **(Please note that you still need to check the boxes for sharing any Sensitive Information if you wish to authorize release of this information.)**

Only the information specified below: (**Please check each one that applies)**:

- ☐ Eligibility/Benefits
- ☐ Enrollment
- ☐ Claims Information
- ☐ Clinical Notes
- ☐ Medical Information (diagnosis, treatment, medication)
- ☐ Premium Information/ Resolve Billing Questions/Problems
- ☐ Referrals and Authorization of Medical Services

PART E: I ALSO APPROVE THE RELEASE OF SENSITIVE INFORMATION

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. *****I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand and agree that the below information will only be disclosed if I **place my initials** in the applicable space next to the type of information. **Please note:** The signature of a minor is required to authorize Providence Health Plan to release certain sensitive health information pertaining to the minor.

_____AIDS or HIV

_____Alcohol/Drug/Substance Abuse (Diagnosis, treatment or referral information) *

_____Genetic Information (services or tests)

_____Maternity/Pregnancy (Reproductive Health)

_____Mental Health Data and Records

_____Sexually transmitted illness/disease (testing and treatment)

PART F: PERMISSION TO ACT ON MY BEHALF

☐ To perform **EVERY ACT** listed below

OR

To perform **ONLY** those acts ***check marked below***:

- ☐ Request a new ID card
- ☐ Change my Address
- ☐ Inquire/Choose/Change my Primary Care Physician
- ☐ Enroll/Disenroll me from the plan
- ☐ Correct missing/erroneous demographic information (age, gender, marital status, race)

PART G: DATE YOUR AUTHORIZATION EXPIRES: (check one):

Please check the below **expiration date** you wish to have for this authorization:

- ☐ **Maximum** allowed time of **12 months** from the date of signature
- ☐ Other Date/Event listed here: (**Only If** less than 12 months)

If there is no earlier expiration date/event indicated, this authorization shall be in force and in effect until it expires 12 months from the date of signature.

PART H: REVOCATION AND REVIEW

I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization, except to the extent that Providence Health Plan already has already acted in reliance on my Authorization. Any uses or disclosures already made with my Authorization cannot be taken back. To revoke this Authorization, please send a written statement to Providence Health Plan at P.O. Box 4327, Portland, OR 97208-4327 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include your name, ID# and date of birth, the name of the person(s) whom you would like to revoke from receiving your protected health information.

The revocation will be effective immediately upon Providence Health Plan's receipt and processing of your written statement. **Please note:** that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be done in writing.

I have read the contents of this authorization. I understand, agree, and allow Providence Health Plan to use and disclose my information as I have stated above. I also understand that signing this authorization form is of my own free will. I understand that Providence Health Plan does not require that I sign this authorization form in order for me to receive treatment, payment, or for enrollment or being eligible for benefits. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-

disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

PART I: APPROVAL MEMBER (SIGNATURE AND DATE)

By:_____ **Date:**_____

(Member Signature)

- OR –

By:_____ **Date:**_____
(Member's Designated Legal Representative/Guardian Signature)

Relationship to member: ☐ **Parent** ☐ **Legal guardian*** ☐ **Holder of Power of Attorney***

***If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney**

- ***Note: To parents/legal guardians of minors: state laws may prohibit Providence Health Plan from acting on your request about Sensitive Information without written authorization from the minor member. (Both parent and minor must sign)***

PLEASE KEEP A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS