Providence Health Assurance

MEMBER AUTHORIZATION FORM

Complete this form to authorize Providence Health Assurance (PHA) to share your health information with other individual(s). Please use your member identification (ID) card to help you complete the information in Part A.

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PART A: MEMBER INFORMATION ***(Provide your name and personal information)***		
Member Last Name	Member First Name	Middle Initial
Member Date of Birth	Member Identification Number (see your ID card)	Group Number (see your ID card)
Member Home/Street Address	City, State, and Zip Code	Preferred Phone Number

PART B: INDIVIDUAL(S) WHO MAY RECEIVE MY INFORMATION *(Name of the individual(s) you are authorizing to receive your health information)*

I understand the below-named individual(s) must be 18 years of age or older.

1. Name of authorized individual: _____

   Relationship to Member: ☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Caretaker ☐ Broker ☐ Other

2. Name of authorized individual: _____

   Relationship to Member: ☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Caretaker ☐ Broker ☐ Other

3. Name of authorized individual: _____

   Relationship to Member: ☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Caretaker ☐ Broker ☐ Other

PART C: PURPOSE OF MY AUTHORIZATION *(Select your reason for making this authorization by checking the appropriate box below)*

☐ Member Request (personal reason)

☐ Other (please specify): _____

PART D: INFORMATION THAT CAN BE SHARED BY PHA *(Select the information you are authorizing to release by checking the appropriate box(es) below)*

- ☐ Appeals
- ☐ Benefits and Coverage
- ☐ Claims and Payment Information
- ☐ Clinical Notes
- ☐ Diagnosis and Procedure
- ☐ Eligibility and Enrollment
- ☐ Financial
- ☐ Premium Information/Resolve Billing Questions/Problems
- ☐ Referrals and Preauthorizations for Medical Services
- ☐ Other (please specify): _____

PART E: SENSITIVE INFORMATION THAT CAN BE SHARED BY PHA *(Write your initials on the line next to each type of sensitive information you are authorizing to share)*

If our records contain any of the types of information listed below, additional laws relating to the use and disclosure of the information may apply.

I understand that certain types of sensitive information, including some that are related to alcohol/substance use, are protected under Federal and State privacy 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 **write my initials on the line next to the specified sensitive information.*

_____ HIV (testing and treatment)	_____ Mental Health Data and Records
_____ *Alcohol/Drug/Substance Use (diagnosis, treatment, referral information)	_____ Maternity/Pregnancy (reproductive health)
_____ Genetic Information (services or tests)	_____ Sexually Transmitted Illness/ Disease (testing and treatment)

Please note: To parents/legal guardians of minors, some state laws may prohibit PHA from acting on your request about Sensitive Information without written authorization from the minor member.

_____	_____
Minor Member's Signature	*Date*

PART F: PERMISSION TO ACT ON MY BEHALF ***(You may authorize the individual(s) named in Part B to perform administrative functions on your behalf as indicated below)***

- ☐ Request a new ID card
- ☐ Change my address
- ☐ Inquire/choose/change my primary care provider
- ☐ Enroll/disenroll me from the plan
- ☐ Correct missing/erroneous demographic information (age, gender, marital status, race)

PART G: DATE YOUR AUTHORIZATION EXPIRES (This authorization will remain in effect for three (3) years from the date it is signed unless you specify an earlier expiration date)

☐ Three (3) years ☐ Other/earlier expiration date (please specify): _____

California Residents: An authorization form in California generally expires one (1) year from the date it is signed unless a different expiration date is specified. The maximum expiration date permitted by PHA is three (3) years.

PART H: REVOCATION AND ACKNOWLEDGEMENT ***(Your rights related to this authorization, including the right to revoke your authorization)***

You have the right to revoke this authorization in writing any time prior to the expiration date. If you do revoke your authorization, your information will no longer be used or disclosed for the purposes stated in this authorization, except for any actions PHA has already taken based on your previous authorization. Any uses or disclosures already made with your authorization cannot be undone.

To add authorized individuals or to make other changes to your authorization, please complete and submit a new authorization form. To revoke an existing authorization, please send a written request to revoke the current form on file. The revocation will take effect as soon as PHA receives and processes your written request. Your request must include your full name, member ID number, and date of birth and should be mailed to: Providence Health Assurance at P.O. Box 5548, Portland, Oregon, 97228-5548.

By signing in Part I, you acknowledge and accept the following:

"I understand, agree, and allow Providence Health Assurance to use and disclose my information as I have indicated above. I attest that I am signing this authorization form of my own free will. I understand that Providence Health Assurance does not require that I sign this authorization form for me to receive treatment, payment, or be eligible for benefits.

I understand that once my information is shared, it may be used and disclosed by the authorized person and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information."

PART I: MEMBER AUTHORIZATION *(To finish your authorization, sign your name and write the date below)*

Member's Signature *Date*

Member's Designated Legal Representative/Guardian Signature *Date*

Relationship to Member: ☐ *Parent of a Minor* ☐ **Legal Guardian* ☐ **Power of Attorney*

**If this form is signed by someone other than the member, please attach authorizing legal documentation of guardianship or power of attorney.*

PART J: RETURN THE COMPLETED FORM TO PROVIDENCE HEALTH ASSURANCE

Email:	Fax:	Mail:
memberauthorizationrequest@providence.org	503-574-8116	Providence Health Assurance Attn: Customer Service P.O. Box 5548 Portland, Oregon 97228-5548

If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th, we are closed Saturdays and Sundays.

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS