Providence Medicare Advantage Plans
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthAssurance.com

PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

{MergeDateTime}

{MEM_FIRST_NAME} {MEM_MID_INIT} {MEM_LAST_NAME} {MEM_TITLE}
{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_Mid_Init} {Mem_Last_Name}:

Enclosed is a Member Authorization form. Please complete the entire form, sign it and return it to Providence Medicare Advantage Plans.

Release of Member Information Requirements

Providence Medicare Advantage Plans is committed to protecting the privacy of our members. Occasions can and do arise when a loved one needs to assist with various decisions regarding a member's health insurance, financial arrangements, primary care physician selection and other matters. These occasions are typically the result of a member's failing health or declining mental state. To better serve the needs of our Providence Medicare Advantage Plans members and their families; please be advised of our policy regarding the disclosure of member information.

Providence Medicare Advantage Plans will not release member information to family and friends without having one (or more) of the following active forms on file:

- ☐ A copy of a legal document indicating a court appointed legal guardian or conservator.
- ☐ Power of Attorney for Healthcare and Directive to Physicians.
- ☐ A Member Authorization form (attached).
- ☐ A copy of a General Power of Attorney (with specific language that allows the designee to make changes or obtain information).

Due to variations in content, the above documents do not guarantee your loved ones the same access to information and decision-making power as the member or the member's legal guardian.

You may send your Member Authorization form to Providence Medicare Advantage Plans at:

Providence Medicare Advantage Plans
PO Box 5548
Portland Oregon 97228-5548

You may fax your Member Authorization form to 503-574-8608 or you may hand deliver it *(if mailing, use only the post office box address listed above*) to the following address:

Providence Medicare Advantage Plans
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

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

If you have any other questions or concerns, you may contact the Providence Medicare Advantage Plans Customer Service Team at 503-574-8000 or 1-800-603-2340. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you,

Providence Medicare Advantage Plans

MEMBER AUTHORIZATION FORM

By completing the Member Authorization form, you are telling Providence Medicare Advantage Plans that you chose the named person in Part B below and this form allows Providence Medicare Advantage Plans 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 Medicare Advantage Plans 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)

MEMBER AUTHORIZATION FORM

Use this form to authorize Providence Medicare Advantage Plans 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 THIS 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 MEDICARE ADVANTAGE PLANS

I allow the following information to be disclosed by Providence Medicare Advantage Plans 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 initial 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 Medicare Advantage Plans 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 Medicare Advantage Plans 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 Medicare Advantage Plans at P.O. Box 5548, Portland, OR 97228 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 Medicare Advantage Plans' 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 Medicare Advantage Plans 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 Medicare Advantage Plans 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 Medicare Advantage Plans 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 FORM FOR YOUR RECORDS