Providence
Health Assurance

P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthPlan.com

health share
Health Share of Oregon

Here is the release of information consent form you asked for. Please complete the entire form, sign it and return it to Providence Health Assurance at:

PROVIDENCE HEALTH ASSURANCE
ENROLLMENT DEPARTMENT

SALEM, OR 97309

You may fax your release of information consent form to 503-584-4234. Or you can hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Assurance
Attn: Customer Service
P.O. Box 14590
3601 SW Murray Blvd. #10
Beaverton, Oregon 97005-2359

Please note: This consent form must be completed, signed and dated.

You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-898-8174 or TTY:711. We accept relay calls.

Sincerely,

Providence Health Assurance
Enclosure

Providence Health Assurance

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MEMBER CONSENT FORM

Completing this form is important. It tells Providence Health Assurance (PHA) that the person you named in Part B below allows PHA to release your Protected Health Information (PHI) and Personally Identifiable Information (PII) to that person.

Part A. Your healthcare information.

Part B. Name of the person or company you're allowing to receive your PHI/PII.

Part C. The reason(s) for your consent.

Part D. Tell us what details may be released.

All details: Check if you want "all PHI" as listed to be shared with the person or company named in PART B. This won't include Sensitive Health Information.

Or

Only the details you list: Check each item you're allowing.

Part E. Tell us what details may be released.

Sensitive Health Information: You'll need to place your initials next to the Sensitive Information if you want these details to be released. **Please note:** If you want to release them to a parent or legal guardian, a minor's signature is required. This will allow PHA to release the information. (Both the minor and parent/guardian must sign the form for it to be valid.)

Part F. You may allow the person in PART B to do approved work for you.

Part G. Date your consent expires

Part H. You understand what it means if you cancel.

PART I. Your approval (signature & date)

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This form allows PHA to use or release details of your health to another person or company. The form must be completed in full for it to be valid. Please fill in spaces below 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 name below:

Name: _____

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

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

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

_____

(Only applies for a given reason or event. An example might be to settle a claim or a one-time release)

☐ Legal Purpose

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PART D: DATA THAT CAN BE RELEASED BY PROVIDENCE HEALTH ASSURANCE

I allow the following to be released by PHA on my behalf to the person in PART B.

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

Check if you allow all PHI to be shared with the person or company listed in Part B above. This won't include Sensitive Health Data. **(Please note that you still need to check the boxes for sharing any details if you want them to be released.)**

Only the details listed below: (Check all that apply):

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

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PART E: I ALSO APPROVE THE RELEASE OF SENSITIVE DATA

If the data to be used/released contains any of the types of records or information listed below, additional laws may apply.* I understand that federal and state privacy laws and rules protect my alcohol/substance abuse records. These records cannot be released without my written approval unless stated differently. I understand that the details below will only be released if I **place my initials** in the correct space next to it. **Please note:** A minor's signature is required to allow PHA to release certain details affecting the minor.

_____AIDS or HIV

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

_____Genetic Information (services or tests)

_____Maternity/Pregnancy

_____Mental Health Data and Records

_____Sexually transmitted illness/disease (testing and treatment)

PART F: CONSENT 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

☐ Choose/Change my Primary Care Physician

☐ Enroll/Unenroll me from the plan

☐ Correct missing/incorrect data (age, gender, marital status, race)

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

Please check which **expiration date** you wish to have for this consent:

- ☐ **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 consent shall be valid until it expires 12 months from the date of signature.

PART H: CANCELLATION AND REVIEW

I can cancel this consent in writing at any time. If I cancel, the details I provided won't be used or released for the reasons I've given. However, I understand that PHA may have already used my information. Any consent I've already approved can't be taken back. To cancel this consent, please send a written letter to:

PROVIDENCE HEALTH ASSURANCE
ENROLLMENT DEPARTMENT
PO BOX 14590
SALEM, OR 97309

Let us know that you're cancelling. Please include a copy of the original consent form if available. Otherwise, please include your name, ID# and date of birth. Also include the name of the person(s) who should not receive your protected health information.

The cancellation will start as soon as PHA receives and processes your written letter. **Please note:** if you've allowed the release of ONLY alcohol or substance use treatment records, you may cancel this action verbally. You must cancel all other types of health care records in writing.

I have read through this form. I understand, agree, and allow PHA to use and release my health details as I've stated above. I also understand that:

- Signing this form is of my own free will.
- PHA doesn't require me to sign this form to receive treatment, payment, or for enrollment or being eligible for benefits.
- The details used or released may re-released. They will no longer be protected under federal law.

Federal or state law may restrict re-releasing of:

- HIV/AIDS tests or results
- Mental health details
- Genetic details
- Drug/alcohol diagnosis, treatment, or referral details

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PART I: APPROVAL MEMBER (SIGNATURE AND DATE)

By:_____ **Date:**_____

(Member Signature)

- OR –

By:_____ **Date:**_____

(Member's Chosen 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 proof if you're the legal guardian or Holder of Power of Attorney.**

- ***Note to parents/legal guardians of minors: state laws may prevent PHA from allowing sensitive details to be released without the minor member's written approval. (Both parent and minor must sign.)***

PLEASE KEEP A COPY OF THIS CONSENT FORM FOR YOUR RECORDS

You can get this form in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-898-8174 or TTY:711. We accept relay calls.

Non-discrimination Statement
Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discrimination the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people (including members and potential members), or treat them differently or unfairly because of race, color, national origin, age, disability, health status, sexual orientation, religion, gender identity, marital status or sex.

Everyone has a right to enter, exit, and use buildings and services. Providence Health Plan and Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, Braille other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, you can call us at 1-800-898-8174 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, health status, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, call us at 1-800-898-8174 (TTY:711) for assistance.

You also have a right to file a complaint with the Oregon Health Authority (OHA) Office of Civil Rights. Contact that office in one of these ways:

Web: www.oregon.gov/OHA/OEI Email:
OHA.PublicCivilRights@state.or.us
Phone: (844) 882-7889, 711 TTY
Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204

You also have a right to file a complaint with the Bureau of Labor and Industries Civil Rights Division. Contact that office in one of these ways:

Phone: (971) 673-0764
Email: crdemail@boli.state.or.us
Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St., Suite 1045, Portland, OR 97232

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail, phone or email at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)
Email: OCRComplaint@hhs.gov

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

You can get this letter in any way that is best for you. This includes, but is not limited to, different languages, large print, and alternative formats. Oral presentation, oral interpretation, sign language interpretation, and Braille are also available. All formats, auxiliary aids, and services are free. Call Customer Service at 503-574-8200. The toll-free number is 1-800-898-8174. Our TTY/TDD number is 711. Our team will help you get what you need.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то *Вам доступны услуги бесплатной языковой поддержки*. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-898-8174 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174 (TTY: 711)まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174(TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-898-8174 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711).