RELEASE OF INFORMATION

PLEASE COMPLETE THIS FORM SO WE CAN SHARE YOUR INFORMATION

PO BOX 14590 SALEM, OR 97309
Fax: 503-584-4234

Your information

Name: ______________________________________ ID #: ____________________________

Address:

____

Date of Birth: ______________________________ Phone Number:(_____) ____________________

Who may we release your information to?

Name: ____

Address:

____

______________________________ Phone Number:(_____) ____________________

Why would you like to share your information?

____At my request, or

____For this reason(s): ____

____

What types of information may we share?

____Premium information
____Benefit information
_____Claim information
_____Authorization of medical services

Please let us know if there are any limits to the information you'd like to share. For example:

- "Only share information about my back surgery."

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What types of sensitive information may we share?

Some types of information are sensitive. Sensitive information may be protected by other laws. Please write your initials next to types of sensitive information we may share.

______HIV/AIDS ______Genetic testing

______Mental health ______Drug/alcohol

What actions can this person take for you?

You may allow someone to make certain changes for you. Check any actions they can take.

______Change member's address

______Change member's doctor

When should we stop sharing your information?

Unless you cancel it, this authorization will be in place until:

______Date: ________________________________

______Event: ____

This authorization will expire in two years. If you would like to extend this authorization, you must file a new authorization form when this one expires.

Notification

Your signature below means that you understand that:

- You have the right to refuse to sign this form.
- Refusing to sign this form will not affect your coverage with us.
- You have the right to cancel this Authorization at any time. To cancel it, send us a written statement and a copy of the Authorization you'd like to cancel.
- We cannot take back information we shared before we got your cancellation. No more information will be released once we get your cancellation.
- The information we share as a result of this authorization may be re-shared by the person we send it to. The information may no longer be protected by law. Sensitive information may still be protected by law.

Signature(s)

I have read and understand this authorization.

Signature: ______________________ Date: __________

Relationship to the member: ______________________