PHI Authorization Form

Providence Health Plan | POWERED BY Collective Health

Please complete all sections of this HIPAA-compliant release form. If any sections are left blank, this form will be invalid and it will not be possible for Collective Health to share your health information as requested.

Collective Health Member Information

Member Name

Address

Date of birth

Phone

Subscriber ID or last 4 of SSN

E-mail (optional)

Authorization

I, _____, hereby authorize Collective Health to share the following information with the person(s) or organization(s) I have specified in this document.

Member's PHI: What Information can be Disclosed?

☐ **Full Access**
All healthcare information including sensitive care. Allows Collective Health to share and discuss the Member's healthcare information including: specific descriptions of care (including sensitive care), dates of care, costs for care, provider name, prescriptions, and details of your claims. Sensitive care includes care related to reproductive health (including contraception, pregnancy, and abortion), abuse or assault, sexual health, AIDS/HIV, mental health, and substance-use disorders. All healthcare information except sensitive care information.

☐ **Limited Access**
Allows Collective Health to share and discuss the Member's healthcare information as allowed under Full Access, except for details regarding sensitive care.

☐ **Specific Information**
Only the information maintained by Collective Health specified below

Who Can Receive My Information

Name(s)

Address(es)

Phone Number(s)

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Signature

By signing below, you confirm your understanding that:

- This authorization is at your request and for your own purposes.
- You can change or revoke your authorization at any time by contacting Collective Health. Any revocation will not be retroactive.
- The information disclosed in accordance with this authorization may be redistributed by the authorized recipient, and this re-distribution is not prohibited or regulated by HIPAA and its implementing regulations.
- This authorization will not affect the payment or treatment by,or your eligibility or enrollment in your healthcare plan.

Expiration

- Current members: This authorization will remain in place so long as you are covered under the Plan, or until you revoke consent in writing.
- Former members: This authorization will expire 1 year from the date you unenroll from the Plan.

Signature

Member Name (Print)

Date (mm/dd/yyyy)