PROVIDENCE Health Plan

Authorization To Use/Disclose Protected Health Information

Release by Providence Health Plans/Providence Medicare Advantage Plans to a Third Party

THIS AUTHORIZATION FORM MUST BE COMPLETED IN FULL FOR IT TO BE VALID.

Member: _____ ID #: _____

Group Name: _____ Group #: _____

I authorize: **Providence Health Plans/Providence Medicare Advantage Plans** to disclose my protected health information to:

_____

(Name and address of recipient(s) **Agencies/Groups/Providers Only:** Please also include your Tax ID #)

for the purpose(s) of:

RELEASE OF INFORMATION:

_____ Premium Information _____ Claim Information

_____ Benefit Information _____ Authorization of Medical Services

If you wish to specify a date range or limit the type of information for the above options, please list below:

_____

_____

PERMISSION TO ACT ON MY BEHALF to:

_____ Change my address

_____ Inquire/change my Primary Care Physician (PCP)

_____ Enroll me/disenroll me

_____ Do and perform all acts necessary as I might do (including but not limited to the above items)

(Describe <u>each</u> additional purpose of the use/disclosure):

_____

_____

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this Authorization. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I **place my initials** in the applicable space next to the type of information to be included with the disclosure:

_____ HIV/AIDS test or result information and related records
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in Providence Health Plans or eligibility for health plan benefits.

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. Any uses or disclosures already made with my Authorization cannot be taken back.

To revoke this Authorization, please send a written statement to Providence Health Plans at P.O. Box 4327, Portland, OR 97208-4327 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization.

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.

Unless revoked, this Authorization shall be in force and effect until it expires 24 months from the date of signature or until the following earlier event/date indicated below:

☐ Date: _____ OR

☐ Event: _____

at which time this Authorization to use or disclose this protected health information expires.

I have reviewed and I understand this Authorization.

By:_____ Date:_____
(Individual)

- OR –

By:_____ Date:_____
(Individual's representative)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

***Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney**

Providence Health Plan is a Medicare Advantage organization with a Medicare contract.