PROVIDENCE
Health Plan

Providence Commercial Small Group

Authorization to Use/Disclose Protected Health Information

Release by a Third Party to Providence Health Plan

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

I authorize: ____
Provider's full name (e.g., Dr. Jane C. Doe, M.D.)   Street Address   City/State/Zip

to disclose a copy of the specific health information described below regarding:

Name of Individual: ____________________________________ **Date of Birth:** ____________________
First Name, Middle Initial, Last Name

to Providence Health Plan (PHP) for their evaluation of services received and/or claims submitted after my health insurance coverage began. The specific health information to be used/disclosed consists of:

- **All medical records for the last six months prior to my coverage effective date of ______________________.**

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 types of records of information listed immediately below, additional laws relating to the 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

________ Drug/alcohol diagnosis, treatment or referral information   ________ Genetic testing information

I understand that I have the right to refuse to sign this Authorization, but such refusal may prevent further action by Providence Health Plan regarding my health insurance coverage and/or claims related to that coverage.

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 the 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 Plan 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 will/shall be in force and effect until the following (check one):

Date:______________________________ -OR- Event: ______________________________

at which time this Authorization to use or disclose protected health information expires. Further, this Authorization expires 24 months from the date of signature. 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

Mail to:
Providence Health Plan
Customer Service/Small Group
PO Box 4327, Portland, OR 97208-4327

or Fax to: 503-574-8612