Release of Member Information Requirements

Providence Health Plan is committed to protecting the privacy and confidentiality of our members. Occasions can and do arise when a loved one needs to assist with various decisions regarding a member's health insurance, financial arrangements, primary care physician selection and other matters. These occasions are typically the result of a member's failing health or declining mental state. To better serve the needs of our Providence Medicare Advantage members and their families; please be advised of our policy regarding the disclosure of member information.

Providence Health Plan will not release member information to family and friends without having one (or more) of the following active forms on file:

- A copy of a legal document indicating a court appointed legal guardian or conservator.
- Power of Attorney for Healthcare and Directive to Physicians.
- A valid Advance Directive (requires two signed physician statements attesting to the member's incapacitated state).
- A written consent form from the member.
- A copy of a General Power of Attorney (with specific language that allows the designee to make changes or obtain information).

Due to variations in content, the above documents do not guarantee your loved ones the same access to information and decision-making power as the member or the member's legal guardian.

For your convenience we have included an Authorization To Use/Disclose Protected Health Information. If the need arises and you decide to use this form, please complete the entire form, sign it, date it and specify effective dates. Once complete, return it to Providence Health Plan. You may send your release of information consent form to Providence Health Plan at:

Providence Health Plan
Providence Medicare Plans
PO Box 5548
Portland, Oregon 97228-5548

You may fax your release of information consent form to 503-574-8607 or 1-800-989-7476 or you may hand deliver it (*if mailing use only the post office box address listed on the previous page*) to the following address:

Providence Health Plan
3601 SW Murray Blvd #10
Beaverton, Oregon 97005-2359

If you have any other questions or concerns you may contact the Providence Medicare Advantage Plans Customer Service Team at 503-574-8000 or 1-800-603-2340. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you.
Providence Medicare Advantage Plans

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.