Providence Health Plan
P.O. Box 4327
Portland, OR 97208-4327
www.ProvidenceHealthPlan.com

PROVIDENCE
Health Plan

{MergeDateTime}

{MEM_FIRST_NAME} {MEM_MID_INIT} {MEM_LAST_NAME} {MEM_TITLE}
{MEM_ADDR1}
{MEM_ADDR2}
{MEM_ADDR3}
{MEM_CITY} {MEM_STATE} {MEM_ZIP}

Member ID#: {Sub_ID}{Mem_Sfx}
Group Name: {Group_Name}

Dear {Mem_First_Name} {Mem_Last_Name}:

Enclosed is the release of information consent form you requested. Please complete the entire form, sign it and return it to Providence Health Plan. You may send your release of information consent form to Providence Health Plan at:

Providence Health Plan
Attn: Customer Service
PO Box 4327
Portland Oregon 97208-4327

You may fax your release of information consent form to 503-574-8731 or 800-425-0199 or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
Attn: Customer Service
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

Please Note: The enclosed consent form must be completed, signed, dated and specify effective dates.

If you have any questions or concerns you may contact your Customer Service Team at 503-574-7500 or 1-800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1-888-244-6642. Customer Service representatives are available Monday through Friday, between 8 a.m. and 5 p.m.

Sincerely,

Providence Health Plan
Enclosure

Providence Health Plan
P.O. Box 4327
Portland, OR 97208-4327
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MEMBER AUTHORIZATION FORM

THIS AUTHORIZATION FORM MUST BE COMPLETED IN FULL FOR IT TO BE VALID.
Please complete the following information exactly as it appears on your member Identification (ID) card. If necessary, call the number listed on your member ID card for assistance.

PART A: MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number (See your member ID card)**	**Group Number (See your member ID card)**
Member Street Address	**City and State**	**ZIP Code**

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION	
The following people, facility or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and list the company/facility name or the first and last name of the persons who you are authorizing.	
☐ **My spouse/domestic partner** (provide first and last name)	☐ **My parent(s)** (provide first and last name)
☐ **My friend/caretaker** (provide first and last name)	☐ **My insurance broker or agent** (provide the name of the company and first and last name) **(only applies if you have a broker/agent)**
☐ **My adult children** (provide first and last name)	☐ **Facility** (provide name of facility) Provide first and last name of persons from facility or indicate "all persons" from the facility **(only applies if you are living in a facility)**
☐ **Other** (provide first and last name or name of company)	☐ **One time release** (provide first and last name or name of company and address)

PART C: THE PURPOSE OF MY AUTHORIZATION (check one):

☐ To give out the information shown on this form ***(As listed in PART D)***

OR

☐ Only for this reason/event(s): ____

(Only applies for a specific reason or event, an example might be to settle a claim)

PART D: INFORMATION THAT CAN BE RELEASED BY PROVIDENCE HEALTH PLAN

I allow the following information to be released by Providence Health Plan on my behalf to the person in PART B.

(**Please check each one that applies**):

- ☐ Referrals and Authorization of Medical Services
- ☐ Benefits and Claims Information
- ☐ Premium Information /Resolve Billing questions/problems
- ☐ Behavioral Health (OPTUM/PBH) **(If you check this box, please initial mental health in PART E)**

PART E: I ALSO APPROVE THE RELEASE OF SENSITIVE INFORMATION

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 that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

I understand and agree that the below information will only be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure

(Initial all that apply):

___ Alcohol/Drug/Substance Abuse *

___ Genetic testing

___ HIV or AIDS

___ Mental health

PART F: PERMISSION TO ACT ON MY BEHALF

☐ To perform **EVERY ACT** listed below

OR

To perform **ONLY** those acts ***check marked below***:

- ☐ Request a new ID card
- ☐ Change my Address
- ☐ Inquire/Change my Primary Care Physician (PCP)
- ☐ Enroll/Disenroll me
- ☐ Correct missing/erroneous demographic information (Age, gender, marital status, race)

PART G: DATE YOUR AUTHORIZATION EXPIRES: (check one):

Please check the below **expiration date** you wish to have for this authorization:

- ☐ **Maximum** allowed time of **24 months** from the date of signature
- ☐ Other Date/Event listed here: (**Only If** less than 24 months) ________________________________

____

If there is no earlier expiration date/event indicated, this authorization shall be in force and in effect until it expires 24 months from the date of signature.

PART H: REVIEW AND APPROVAL

I have read the contents of this authorization. I understand, agree, and allow Providence Health Plan to the use and release of my information as I have stated above. I also understand that signing this authorization form is of my own free will. I understand that Providence Health Plan does not require that I sign this authorization form in order for me to receive treatment or payment, or for enrollment or being eligible for 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 person whom you would like to revoke from receiving your protected health.

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.

____ **Date:**________________

(Member Signature)

- OR –

By:____ **Date:**________________

(Member's Designated Legal Representative/Guardian Signature)

Legal representative print full name:____

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**

**Note: This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.*

Please keep a copy of this form for your records