Providence Health Assurance
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthAssurance.com/OHP

«AddressBlock» «todays_date»

Dear «first_name» «middle_name» «last_name»,

Here is the release of information consent form you asked for. Please complete the entire form, sign it and return it to Providence Health Assurance at:

PROVIDENCE HEALTH ASSURANCE
ENROLLMENT DEPARTMENT
PO BOX 14590
SALEM, OR 97309

You may fax your release of information consent form to 503-584-4234. Or you can hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

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

Please note: This consent form must be completed, signed and dated.

If you have any questions, need this in large print, braille or a different language, please call us Monday through Friday, 8 a.m. to 5 p.m., at 800-898-8174 (TTY:711).

Sincerely,

Providence Health Assurance
Enclosure

MEMBER CONSENT FORM

Completing this form is important. It tells Providence Health Assurance (PHA) that the person you named in Part B below allows PHA to release your Protected Health Information (PHI) and Personally Identifiable Information (PII) to that person.

Part A. Your healthcare information.

Part B. Name of the person or company you're allowing to receive your PHI/PII.

Part C. The reason(s) for your consent.

Part D. Tell us what details may be released.

All details: Check if you want "all PHI" as listed to be shared with the person or company named in PART B. This won't include Sensitive Health Information.

Or

Only the details you list: Check each item you're allowing.

Part E. Tell us what details may be released.

Sensitive Health Information: You'll need to place your initials next to the Sensitive Information if you want these details to be released. **Please note:** If you want to release them to a parent or legal guardian, a minor's signature is required. This will allow PHA to release the information. (Both the minor and parent/guardian must sign the form for it to be valid.)

Part F. You may allow the person in PART B to do approved work for you.

Part G. Date your consent expires

Part H. You understand what it means if you cancel.

PART I. Your approval (signature & date)

This form allows PHA to use or release details of your health to another person or company. The form must be completed in full for it to be valid. Please fill in spaces below exactly as it appears on your member identification (ID) card.

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 Home/Street Address	**City and State, Zip Code**	**Preferred phone #:**

PART B: PERSON OR COMPANY WHO WILL RECEIVE YOUR INFORMATION

The following person(s), facility or company have the right to receive my protected health/personal information. (They must be 18 years of age or older). Please fill in name below:

Name: _____

Relationship to Member: _____
(Spouse/Domestic Partner/Friend/Caretaker/Broker/Other)

PART C: THE REASON FOR MY CONSENT (check one):

☐ Personal use
☐ Only for this reason/event(s):
_____

(Only applies for a given reason or event. An example might be to settle a claim or a one-time release)
☐ Legal Purpose

PART D: DATA THAT CAN BE RELEASED BY PROVIDENCE HEALTH ASSURANCE

I allow the following to be released by PHA on my behalf to the person in PART B.

☐ **All details (as listed to the right)**:

Check if you allow all PHI to be shared with the person or company listed in Part B above. This won't include Sensitive Health Data. **(Please note that you still need to check the boxes for sharing any details if you want them to be released.)**

Only the details listed below: (**Check all that apply)**:

- ☐ Eligibility/Benefits
- ☐ Enrollment
- ☐ Claims
- ☐ Clinical Notes
- ☐ Medical Data (diagnosis, treatment, medication)
- ☐ Premiums / Resolve Billing Questions/Problems
- ☐ Referrals and Consent of Medical Services

PART E: I ALSO APPROVE THE RELEASE OF SENSITIVE DATA

If the data to be used/released contains any of the types of records or information listed below, additional laws may apply.***** I understand that federal and state privacy laws and rules protect my alcohol/substance abuse records. These records cannot be released without my written approval unless stated differently. I understand that the details below will only be released if I **place my initials** in the correct space next to it. **Please note:** A minor's signature is required to allow PHA to release certain details affecting the minor.

_____AIDS or HIV

_____Alcohol/Drug/Substance Abuse (Diagnosis, treatment or referral information)*

_____Genetic Information (services or tests)

_____Maternity/Pregnancy

_____Mental Health Data and Records

_____Sexually transmitted illness/disease (testing and treatment)

PART F: CONSENT 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
- ☐ Choose/Change my Primary Care Physician
- ☐ Enroll/Unenroll me from the plan
- ☐ Correct missing/incorrect data (age, gender, marital status, race)

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

Please check which **expiration date** you wish to have for this consent:

☐ **Maximum** allowed time of **12 months** from the date of signature

☐ Other Date/Event listed here: (**Only if** less than 12 months)

If there is no earlier expiration date/event indicated, this consent shall be valid until it expires 12 months from the date of signature.

PART H: CANCELLATION AND REVIEW

I can cancel this consent in writing at any time. If I cancel, the details I provided won't be used or released for the reasons I've given. However, I understand that PHA may have already used my information. Any consent I've already approved can't be taken back. To cancel this consent, please send a written letter to:

PROVIDENCE HEALTH ASSURANCE
ENROLLMENT DEPARTMENT
PO BOX 14590
SALEM, OR 97309

Let us know that you're cancelling. Please include a copy of the original consent form if available. Otherwise, please include your name, ID# and date of birth. Also include the name of the person(s) who should not receive your protected health information.

The cancellation will start as soon as PHA receives and processes your written letter. **Please note:** if you've allowed the release of ONLY alcohol or substance use treatment records, you may cancel this action verbally. You must cancel all other types of health care records in writing.

I have read through this form. I understand, agree, and allow PHA to use and release my health details as I've stated above. I also understand that:

- Signing this form is of my own free will.
- PHA doesn't require me to sign this form to receive treatment, payment, or for enrollment or being eligible for benefits.
- The details used or released may re-released. They will no longer be protected under federal law.

Federal or state law may restrict re-releasing of:

- HIV/AIDS tests or results
- Mental health details
- Genetic details
- Drug/alcohol diagnosis, treatment, or referral details

PART I: APPROVAL MEMBER (SIGNATURE AND DATE)

By:_____ **Date:**_____

(Member Signature)

- OR –

By:_____ **Date:**_____
(Member's Chosen Legal Representative/Guardian Signature)

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

***If this form is signed by someone other than the member or Parent, please attach legal proof if you're the legal guardian or Holder of Power of Attorney.**

- ***Note to parents/legal guardians of minors: state laws may prevent PHA from allowing sensitive details to be released without the minor member's written approval. (Both parent and minor must sign.)***

PLEASE KEEP A COPY OF THIS CONSENT FORM FOR YOUR RECORDS

If you have any questions, need this in large print, braille or a different language, please call us Monday through Friday, 8 a.m. to 5 p.m., at 800-898-8174 (TTY:711).

Non-discrimination Statement

Providence Health Assurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Assurance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 1-800-898-8174 (TTY: 711).

If you believe that Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, call us at 1-800-898-8174 (TTY:711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-898-8174 (TTY: 711).

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Arabic: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. تماس بگیرید 1- 800-898-8174 (TTY: 711) با. می باشد

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-898-8174（TTY: 711）まで、お電話にてご連絡ください.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको िनम्तत भाषा सहायता सेवाहरू िननिःशुल्क रूपमा उपलब्ध छ । फोन गनुुहोस् 1-800-898-8174 (TTY: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: □□□□□□□□□□ □□□□□□□□□□□□□□□□□ □□□□□□□□□□, □□□□□□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□□□□□□□□□□□□□ □□□ □□□□□□□□□ 1-800-898-8174 (TTY: 711)□

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວ້າພາສາ ລາວ, ການບໍ ລການຊ້ວຍເຫ ອດ້ ານພາສາ, ໂດຍ ບເສ ັ ຽຄ່ າ, ແມ ນມພ ້ ອມໃຫ ້ ທ ້ ານ. ໂທຣ 1-800-898-8174 (TTY: 711).