Providence Health Assurance | health share Health Share of Oregon
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthAssurance.com/OHP

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 also fax your release of information consent form to 503-584-4234.

You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-898-8174 or TTY:711. We accept relay calls.

Sincerely,

Providence Health Assurance
Enclosure

Providence Health Plan | Providence Health Assurance

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)

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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

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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.

(Initial all that apply)

_____	AIDS/HIV (testing and treatment)	_____	Maternity/Pregnancy (Reproductive Health)
_____	*Alcohol/Drug/Substance Abuse (Diagnosis, treatment, or referral information)	_____	Mental Health Data and Records
_____	Genetic Information (services or tests)	_____	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)

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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

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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

You can get this form in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-898-8174 or TTY:711. We accept relay calls.

Non-discrimination & Communication Assistance | Providence Health Plan

Sincerely,

Providence Health Assurance