

Authorization to Release Protected Health Information



315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
877-416-4161 (TTY/TDD)
Daily 8 am — 8 pm
www.careoregonadvantage.org

This authorization must be completed in full to be valid.

***Indicates a required field**

*Member Name _____ *ID# _____

I authorize CareOregon to disclose my protected health information to:	*Name _____ Mailing Address _____ City State ZIP _____ Phone number _____ Relationship to Member _____
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***RELEASE OF INFORMATION:**

___ The entire record ___ Only those items initialed below

Dates of service _____

***Please initial information that you do not want CareOregon to use or give out.**

- | | | |
|---------------------------------------|---------------------------|----------------------------|
| ___ Medication list | ___ List of allergies | ___ Immunization records |
| ___ History and physical | ___ Operative report | ___ Discharge summary |
| ___ Pathology report | ___ Visit/encounter notes | ___ Laboratory results |
| ___ X-Ray report | ___ Emergency room record | ___ EKG records |
| ___ Billing records | ___ Dental records | ___ Health plan records |
| ___ Benefit information | ___ Claim information | ___ Physical therapy notes |
| ___ Authorization of medical services | ___ Problem list | |

If the information to be disclosed contains any of the four 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 this information will be disclosed if I place my initials in the space next to the type of information that I authorize CareOregon to release:**

- ___ HIV/AIDS test or result information and related records
 ___ Mental health information
 ___ Genetic testing information
 ___ Drug/alcohol diagnosis, treatment, or referral information

Describe **each** additional purpose of the use/disclosure _____

***My Authorized Representative has my permission to act on my behalf to:**

- | | |
|--------------------------|---|
| ___ Change my address. | ___ Inquire (ask questions to) or change my Primary Care Physician. |
| ___ Enroll/disenroll me. | ___ Do and perform all necessary acts as I might do. |

I understand that I can ask for someone at CareOregon to help me understand how this form will be used.

I understand that if the person or organization that gets this information is not a health care provider or health plan covered by federal privacy laws, the information listed above could be given out by them, and will no longer be protected by those regulations.

I understand that I may look at or ask for copies of any information that will be given out because of this authorization.

I understand that I may refuse to sign this form, and that I do not need to sign it to receive health care or to determine eligibility for benefits, or in order for payment for health care to be made.

However, CareOregon or another health plan can require me to sign this authorization before I enroll in CareOregon so they can find out if I am eligible to become a member, as long as the authorization is not for certain psychotherapy notes.

I understand that I may change my mind and decide to cancel my permission at any time. I understand that if I do that, I need to do that in writing, and send the letter to the person or organization that gave out the information, and who is shown above. I also understand that if I cancel this authorization, the information may have already been used or given out before I changed my mind. Unless I change my mind about giving my permission before 365 days from now, **this authorization will stop 365 days from the date that I signed this form or on a different date that I choose.**

I ask for a different expiration date of _____

Other event that would signal the expiration of this authorization _____

I understand that the person or organization that I am giving permission to use or give out my information may get paid to do that. If the organization that will use or give out this information will get direct or indirect payment for my information, they will complete the following information.

Method of payment: _____

Person or company or clinic that will pay them: _____

I understand that I may have a copy of this form for my records after it is signed.

*Member signature

Date

(If signed by other than member, please send copy of Power of Attorney or other legal document)

*Printed name of member

*Signature of witness

Date

(Must be someone other than the person being authorized)

*Printed name of witness