



CareOregon

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877-416-4161 (TTY/TDD)  
www.careoregon.org

# Authorization to Release Protected Health Information

\*Indicates a required field. All required fields must be completed in full to be valid.

\*Member Name \_\_\_\_\_ \*ID# \_\_\_\_\_

<b>I authorize CareOregon to disclose my protected health information to:</b>	*Name _____
	Mailing Address _____
	City State ZIP _____
	Phone number _____
	Relationship to member _____

\*RELEASE OF INFORMATION: \_\_\_\_\_ The entire record \_\_\_\_\_ Only those items initialed below

Dates of service \_\_\_\_\_

**Please initial information that you want CareOregon to use or give out.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Authorization of medical services | <input type="checkbox"/> Emergency room record | <input type="checkbox"/> Operative report       |
| <input type="checkbox"/> Benefit information               | <input type="checkbox"/> Health plan records   | <input type="checkbox"/> Pathology report       |
| <input type="checkbox"/> Billing records                   | <input type="checkbox"/> History and physical  | <input type="checkbox"/> Physical therapy notes |
| <input type="checkbox"/> Claim information                 | <input type="checkbox"/> Immunization records  | <input type="checkbox"/> Problem list           |
| <input type="checkbox"/> Dental records                    | <input type="checkbox"/> Laboratory results    | <input type="checkbox"/> Visit/encounter notes  |
| <input type="checkbox"/> Discharge summary                 | <input type="checkbox"/> List of allergies     | <input type="checkbox"/> X-Ray report           |
| <input type="checkbox"/> EKG records                       | <input type="checkbox"/> Medication 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 (If signed by other than member, please provide copy of Power of Attorney or other legal document)

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Printed name of member

\_\_\_\_\_  
\*Signature of witness (Must be someone other than the person being authorized)

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Printed name of witness