My authorization for disclosure of Protected Health Information (PHI)

Information about you and your health, called Protected Health Information (or "PHI"), is sensitive. Health plans, such as CareOregon, may not use this PHI or disclose it to anyone unless you say it's OK in writing. This form gives your consent to use and disclose your PHI. You *must* fill out everything marked with a star (*****) for this form to be valid.

*My name (please print member's name) _____

*My CareOregon ID number _____

***I give my consent to CareOregon to use my PHI and disclose it to:**	***Individual or organization: _____ Mailing address: _____ City, State ZIP: _____ Phone number: _____ Relationship to member: _____**

I am asking for my PHI to be used or disclosed because (please list reasons):

_____

_____

***My PHI to be disclosed includes:** ☐ all of it, or ☐ only the items I've checked here:

- ☐ Prior authorizations
- ☐ Claims
- ☐ Benefits
- ☐ Health plan records
- ☐ Billing records
- ☐ Medications

I want CareOregon to limit PHI disclosure to dates or events that I specify below:

- ☐ Dates from: _____ to: _____
- ☐ Event: _____

(for example, if you went to the hospital in June 2011)

Other information that I authorize to be disclosed: The three kinds of PHI listed below are protected by other laws. It is OK for CareOregon to disclose this PHI only if I've initialed the space beside it on this form. **If I haven't initialed it here, CareOregon may not disclose it.**

	Anything about an HIV/AIDS test, including whether I've taken one, the results of a test and other records about it
	Any of my mental health information (excluding psychotherapy notes)
	Any information about drug or alcohol diagnoses, treatment or referrals. (I also understand that federal law says no one who gets drug or alcohol information from CareOregon can disclose it to anyone else unless I also give my written authorization to them.)

I understand my rights about this consent form:

- I can ask for someone from Customer Service at CareOregon to help me understand how this form will be used.
- I know that if the individual or organization that gets this PHI is not a health care provider or health plan covered by federal privacy laws, they might give out the PHI listed above. In that case, my PHI won't be protected under those laws.
- I know that social media platforms (such as Facebook, Instagram, Twitter, Pinterest, etc.), are not secure places to share health information. My participation in groups, acceptance of invitations, submission of content or comments, etc., on social media platforms are not protected by federal privacy laws.
- I may see or get a copy of any PHI that will be given out because I've signed this form.
- **I don't have to sign this form to get health care, to have my health care paid for, to learn if I am eligible for benefits or to enroll in CareOregon.**
- **I can revoke this authorization in writing except when CareOregon has already acted in reliance on it.**
- **I can change my mind and cancel my permission at any time.** If I do change my mind, I must let CareOregon know in writing by sending a letter to:

  Attn: Enrollment Department
  CareOregon
  315 SW Fifth Ave. Suite 900
  Portland, OR 97204

  If I change my mind and cancel this consent, I understand that my PHI may have already been used or given out.

My consent to disclose PHI is limited

Unless I change my mind and sign a new written authorization, my consent to disclose PHI will stop on the following date (check one):

☐ **365 days from the date that I sign this form,**

☐ **or on this date (select a different date):** _____

I may ask for a copy of this form for my records after I sign it.

*My signature: _____ Date _____

(If anyone signs for the member, please provide a copy of Power of Attorney or other legal document giving that permission)

My printed name: _____

Fax completed form to: **503-416-8117**

-or-

Mail to:
Enrollment Department
CareOregon
315 SW Fifth Ave, Suite 900
Portland, OR 97204