

**THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID.**

**Member:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

**Group Name:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

I authorize: **Providence Health Plans** to disclose my protected health information to:

\_\_\_\_\_  
*(Name and address of recipient(s))*

for the purpose(s) of:

\_\_\_\_\_  
*(Describe each purpose of the use/disclosure)*

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this Authorization. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the 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 such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

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

**I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in Providence Health Plans or eligibility for health plan benefits.**

**I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization. Any uses or disclosures already made with my Authorization cannot be taken back.**

**To revoke this Authorization, please send a written statement to Providence Health Plans at P.O. Box 4327, Portland, OR 97208-4327 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization.**

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization will shall be in force and effect until the following (check one):

Date: \_\_\_\_\_ OR

Event: \_\_\_\_\_

at which time this Authorization to use or disclose this protected health information expires.

**Further, this Authorization expires 24 months from the date of signature.**

**I have reviewed and I understand this Authorization.**

By: _____ (Individual)	Date: _____
---------------------------	-------------

- OR -

By: _____ (Individual's representative)	Date: _____
Relationship to member: <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian* <input type="checkbox"/> Holder of Power of Attorney*	
*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney	