TRANSITION OF CARE FORM

ATTN: Case Management Department
PO Box 4327
Portland, OR 97208-4237
503.574.7247 1.800.662.1121
Fax: 503.574.8171

We are pleased you have chosen Providence Health Plan for your health care and look forward to working with you. As you transition to our Plan it is very important for us to understand any special health needs or medical conditions that you or your family members may have. For example, if you are currently receiving care for medical conditions (such as pregnancy in the third trimester, chemotherapy, radiation therapy, or preparing for an organ transplant), have special medication needs or have surgery scheduled in the next few weeks, we can help with your questions or concerns. One of our Nurse Case Managers will contact you. Please complete the following information so that we may take an active role in assisting you with your health care needs

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	DOB	GENDER
ADDRESS			DAY PHONE	
CITY	STATE	ZIP	EVENING PHONE	
EMPLOYER/GROUP NAME **OEBB**			EMPLOYEE NAME	
PRIMARY CARE PHYSICIAN			PHONE	FAX
SPECIALIST PHYSICIAN			PHONE	FAX

PLEASE INDICATE THE CONDITION(S) AND/OR TREATMENT(S) FOR WHICH YOU HAVE NEEDS:

____ **CHRONIC MEDICAL CONDITION**

____ **ACUTE MEDICAL CONDITION OR TRAUMA**

____ **PRESCRIPTION MEDICATIONS**

____ **PREGNANCY**

____ **MENTAL HEALTH/SUBSTANCE ABUSE**

____ **PLANNED SURGERY OR HOSPITALIZATION**

____ **OUTPATIENT THERAPY OR PROCEDURE**

____ **CHEMOTHERAPY/RADIATION THERAPY**

____ **ORGAN OR BONE MARROW TRANSPLANT**

____ **DURABLE MEDICAL EQUIPMENT**

IN THE SPACE BELOW, PLEASE PROVIDE US WITH AS MUCH DETAIL AS POSSIBLE ABOUT THE ITEM(S) MARKED ABOVE:

FOR INTERNAL USE ONLY

Effective Date:	Product:	Sales Contact:

Created on 9/1/2009 9:46:00 AM

FAX 503-574-8171 -OR- MAIL TO: PROVIDENCE HEALTH PLAN
PO BOX 4327 PORTLAND, OR 97208-4327

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

RELEASE BY A THIRD PARTY TO PROVIDENCE HEALTH PLAN

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

I authorize:____

(Name of provider/person/entity disclosing information) *(Address)*

to disclose a copy of the specific health information described below regarding:

Name of Individual: ____ **Date of Birth:** ______________

to **Providence Health Plan (PHP)** for the purpose of coordinating the transition of my care to Providence Health Plan. The specific health information to be used/disclosed consists of (*Describe condition(s), treatment(s), dates of service, etc.)*)

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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

_____ Drug/alcohol diagnosis, treatment, or referral information _____ Genetic testing 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 Plan or my eligibility for 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 Plan 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:____ **Date:**_______________
(Individual)

- OR -

By:____ **Date:**_______________
(Individual's representative)
Relationship to member: ☐ **Parent** ☐ **Legal guardian*** ☐ **Holder of Power of Attorney***
*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

Created on 9/1/2009 9:46:00 AM