PacificSource HEALTH PLANS

Legacy Employee Health Plan

# Authorization to Use/Disclose Protected Health Information

## Instructions

We understand that you may wish us to communicate with others about your healthcare. As you may be aware, certain information regarding your health is protected by state and federal law to help ensure your privacy. We therefore cannot use or disclose your protected health information without your written authorization.

If you wish to grant a person or entity legal permission to access your protected health information, please complete the enclosed form, our Authorization to Use/Disclose Protected Health Information.

The following guidelines will help you complete the form correctly.

- For the authorization to be valid, **all fields must be completed.**
- **Member name** is the name of the specific person whose protected health information is to be released.
- **Group name, ID number, and group number** are shown on your membership card.
- **Recipient or class of recipients** simply means the name and address of the person(s) you wish to have access to your protected health information.
- Information related to **HIV/AIDS test, mental health, genetic testing, or drug/alcohol treatment:** If your health information includes any of these categories, your initials are required on the form to authorize their use or disclosure.
- **Expiration date** is the date you wish your authorization to end. After that date, we do not have your permission to use or disclose your protected health information.
- **Event:** Instead of an expiration date, you may specify an event after which we do not have your permission to use or disclose your protected health information.
- **Signature:** The person whose protected health information is to be released must sign the form in order for the authorization to be valid. If the person is a minor child, their parent or legal guardian may sign for them. If the person is unable to sign for themselves, someone with their power of attorney may sign for them. In the case of legal guardians and holders of power of attorney, legal documentation must be attached.
- When the form is complete, you may fax it to us at **(541) 225-3631** or mail it to:
  **PacificSource Health Plans**
  **Attn: Customer Service**
  **PO Box 7068**
  **Springfield OR 97475**

We are very serious about protecting the personal health information of all our members. We appreciate your cooperation and assistance in helping us comply with state and federal regulations.

If you have any questions or concerns, you are welcome to contact our Customer Service Department by phone at (844) 520-5347 or by email at LegacyEHP@pacificsource.com.

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***To be valid, all fields must be completed, and the member must be given a copy of the completed form.***

Member Name _____ Member ID No. _____

Group Name _____ Group No. _____

I authorize *(person/entity disclosing information)* PacificSource Health Plans to use and disclose a copy of my protected health information to *(name and address of recipient or class of recipients)*

_____

for the purpose 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 a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I have the right to revoke this authorization in writing at any time. If I revoke your authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back. (To revoke this authorization, send a written statement that you are revoking this authorization to our Compliance Department at PacificSource Health Plans, PO Box 7068, Springfield, OR 97475.)

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 be in force and effect until *(check one)*:**

☐ Expiration Date _____ or ☐ Event _____

At which time this authorization to use or disclose this protected health information expires. Neither the specified date nor event shall exceed a period of 24 months.

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

Signature _____ Date _____

Relationship to member ☐ Self ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*

**Please attach legal documentation if you are the legal guardian or holder of power of attorney.*