



AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Willamette Valley Community Health, its agents or subsidiaries, to disclose the personal health information indicated below to the persons or entities specified on this form.

Please print your responses on this form. All sections must be complete for this authorization to be valid:

NAME OF INSURED WHOSE INFORMATION IS TO BE DISCLOSED:

Name of Insured:	
Insured Address:	
Daytime Telephone:	Date of Birth:
Insured's ID Number:	

PERSONS / ENTITIES AUTHORIZED TO RECEIVE PERSONAL HEALTH INFORMATION:

Name:	Name:
Address:	Address:
Phone:	Phone:
Name:	Name:
Address:	Address:
Phone:	Phone:

TYPE OF INFORMATION TO BE RELEASED AND HOW IT WILL BE USED:

I authorize Willamette Valley Community Health to release the following personal health information listed below to the person / entities listed above:

<input type="checkbox"/> All health information	<input type="checkbox"/> Explanation of benefits	<input type="checkbox"/> Health Records (Limited)
<input type="checkbox"/> Eligibility information	<input type="checkbox"/> Claims information	<input type="checkbox"/> Appeal information (appeal # _____)
<input type="checkbox"/> Other: _____		

I understand if the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that the following information will be disclosed **only** if I place my initials in the applicable space next to the type of information:

_____ HIV/AIDS Information (initials)	_____ Mental Health Information (initials)
_____ Genetic Testing Information (initials)	_____ Drug/Alcohol Diagnosis, Treatment, and Referral (initials)

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

By signing this form I authorize the use and disclosure of the personal health information listed above for the following purpose (**please list any limitations you would like to place on the use of this information below**):

ACKNOWLEDGEMENT:

I understand I have the right not to sign this authorization. Refusal to sign this authorization will not affect my enrollment in a health plan or eligibility for health benefits.

I understand I have the right to cancel this authorization in writing at any time. If I cancel this 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.

Unless I cancel it, this authorization will remain valid for twenty-four (24) months from the date of my signature below or until ___/___/___ (if desired, insert an earlier date).

SIGNATURE:

I acknowledge that I have read this authorization and understand it.

* **Signature:**

Print Name:

Date:

Daytime Telephone:

*If I am not the insured, I am:

Parent*** Legal Guardian** Healthcare Power of Attorney**

**If you are the legal guardian or holder of a healthcare power of attorney for the insured, please attach legal documentation.

*****Children of the following ages must sign the "Authorization to Use and Disclose Protected Health Information" form to release their personal health information to any person or entity:**

14 years of age and above – Chemical Dependency

15 years of age and above – All other medical conditions

Please mail to: Willamette Valley Community Health

PO BOX 5550

Salem Oregon 97304

Or fax to: 503-566-9801 Attn: Customer Service

Questions? Call Customer Service at 503-584-2150