PacificSource Medicare

PacificSource Community Health Plans
2965 NE Conners Avenue, Bend OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

Authorization to Use and Disclose Protected Health Information

I hereby authorize PacificSource Medicare, its agents, affiliates, or subsidiaries, to disclose the personal health information indicated below to the persons or entities specified on this form.

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

Member Information to be Disclosed		
Member Name:		
Member Address:		
City:	State:	Zip:
Phone:		
Member ID Number:	Date of Birth:	

Who is Authorized to Receive the Personal Health Information		
Name of People/Entities:		
Address:		
Phone:	Fax:	
Are the authorized people/entities allowed to change the member's Primary Care Physician?	☐ Yes	☐ No
Are the authorized people/entities allowed to change the member's address?	☐ Yes	☐ No

Type of Information to be Released and How it Will be Used

I permit PacificSource Medicare to release the following personal health information listed below to the person / entities listed above:

- Medical Records
- Physical Therapy Records
- Pathology Reports
- Explanation of Benefits
- Health Records
- Claims Payment
- Urgent Care Records
- Billing Statements
- Dental Records
- Emergency Care Records
- Laboratory Reports
- Diagnostic Imaging Reports
- Chart Notes
- Hospital Records (including nursing records and progress reports)
- Any other personal or medical information related to the purpose of this authorization.

I understand if the information 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:

_____ (Initials) HIV/AIDS Information

_____ (Initials) Mental Health Information

_____ (Initials) Genetic Testing Information

_____ (Initials) Drug/Alcohol Diagnosis, Treatment, and Referral

Type of Information to be Released and How it Will be Used (continued)

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

Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

Please list any limitations you would like to place on the use of this information:

_____

_____

Right to Revoke Authorization

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

To revoke this authorization, I must send a written and signed statement stating that I would like to revoke this authorization. Send it to PacificSource Medicare, P.O. Box 7469, Bend, OR, 97708.

Unless I revoke this authorization, it will remain valid for twenty-four (24) months from the date of my signature below, or earlier if requested.

Acknowledgment and Signature of Member

By signing this form, I authorize the use and disclosure of the personal health information listed above. 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 acknowledge that I have read this authorization and understand it.

Signature: _____ Date: _____

Signature of Authorized Representative

Relationship to the Member: _____

Signature: _____ Date: _____

Please provide all legal documentation proving your relationship to the member (Upon request only)

By using this document, you agree to the following conditions: This document is provided as reference material only. You may not alter or modify this document in any manner. The most recent version of this document supersedes all prior versions.

Please keep a copy of this authorization for your records.

Discrimination is Against the Law

PacificSource Community Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource Community Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource Community Health Plans**:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need services, contact Customer Service at (888) 863-3637 or, for TTY users, (800) 735-2900.

- **October 1 – March 31:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week
- **April 1 – September 30:** 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday

If you believe that PacificSource Community Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY 711, fax (541) 684-5264, or email crc@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at OCRPortal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at HHS.gov/ocr/office/file/index.html

Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 863-3637 رقم هاتف الصم والبكم: (800) 735-2900.
Cambodian- Mon-Khmer	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (888) 863-3637, TTY: (800) 735-2900។
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 863-3637, TTY: (800) 735-2900。
Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (888) 863-3637, TTY: (800) 735-2900.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (888) 863-3637, ATS: (800) 735-2900.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 863-3637, TTY: (800) 735-2900.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (888) 863-3637, TTY: (800) 735-2900） まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 863-3637, TTY: (800) 735-2900 번으로 전화해 주십시오.
Persian-Farsi	توجه: اگر بهزبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میسر می‌باشد. با (888) 863-3637, TTY: (800) 735-2900 تماس بگیرید.
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (888) 863-3637, TTY: (800) 735-2900.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 863-3637, телетайп: (800) 735-2900.
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 863-3637, TTY: (800) 735-2900.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 863-3637, TTY: (800) 735-2900.
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (888) 863-3637, телетайп: (800) 735-2900.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 863-3637, TTY: (800) 735-2900.