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

Authorization to Use/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:

- Claims Payment
- Physical Therapy Records
- Pathology Reports
- Explanation of Benefits
- Health Records
- Medical Records
- 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.

Please submit completed forms to us via the following:

Email: MedicareCS@PacificSource.com

Mail: PacificSource Community Health Plans
P.O. Box 7469 Bend, OR 97708-5729

Fax: (541) 322-6423