Instructions: Member Authorization Allowing the Disclosure of Protected Health Information to another Person/Entity

In order for this authorization to be valid, the following areas must be completed:

1. **Member (Patient) Name**
2. **ID #**
3. **Date of Birth**
4. **Group Name**
5. **Group #**

6. **The name and relationship of the recipient or class of recipients to whom the information may be disclosed or used.** This may be an individual's name. It may also be a "class" of recipients such as the "Human Resources department at ABC Company".

7. **The purpose(s) for the disclosure.** The individual must check a box for the purpose of the disclosure. If the 'Other' box is check marked, the individual must state a specific purpose why they are asking for information to be shared.

   Examples of valid purposes are:

   - To discuss the payment of claim #123456789
   - To discuss claim payment concerns for all claims that were sent to ODS relating to my hospitalization of 12/1/2005 to 6/15/06

**Please do not put in "For any purpose" or "Any and all information" as a purpose of the disclosure. We will return an authorization with this purpose as being invalid.

8. **HIV/AIDS test or result information and related records.** If the member desires that we share information, the member must check the corresponding box. No check marks will indicate that no information about this condition will be shared.

9. **Mental health information.** If the member desires that we share information, the member must check the corresponding box. No check marks will indicate that no information about this condition will be shared.

10. **Genetic testing information.** If the member desires that we share information, the member must check the corresponding box. No check marks will indicate that no information about this condition will be shared.

11. **Drug/alcohol diagnosis, treatment or referral information.** If the member desires that we share information, the member must check the corresponding box. No check marks will indicate that no information about this condition will be shared.

12. **Either the date or event box must be checked and filled out.**

- If the date box is checked, there must be a valid future expiration date. The expiration date cannot extend beyond 24 months (2 years) from the date of the requester's signature (in the signature box)

- If the event box is checked, then the event must also be listed.

  Examples would include:

  - Conclusion of Appeal II
  - Independent Review of surgical request

  Under Oregon State Law, an authorization is valid for a maximum of 24 months. If the event stated is still active 24 months from the date of the authorization, a new authorization will need to be sent to ODS. Extensions to existing authorizations are not accepted. An authorization may only be continued past the originally designated period by the completion and submission of a new authorization.

**Listing an event such as "Death", "Termination of Policy" or "Until Revoked" are examples of invalid events which will result in the return of this authorization as being invalid.

13. The authorization must be signed and dated by the individual making the request in order to be valid. If a personal representative of the member is signing on behalf of the member, the applicable information must be attached.

<u>Failure to fill out the following information will result in an "invalid authorization."</u>

- The name or other specific identification of the person(s) or class of persons to whom ODS may make the requested use or disclosure

- The expiration date or an expiration event that relates to the individual or the purpose of the use and disclosure.

- The signature of the individual and date

- If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual and the required documentation.