Member Authorization - Release of Personal Health Information to ODS

Member authorization allows the healthcare provider to use/disclose protected health information to ODS (Oregon Dental Service, ODS Health Plan, Inc. and/or ODS Community Health, Inc.)

(Member Name) Last	**First**	**M.I.**
ID Number		
DOB		
Employer or Group Name		
Group Number		

I authorize:____
(Name of healthcare provider(s)/entity(ies) disclosing information.)
to use and disclose a copy of my protected health information to: **ODS**

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.

I authorize the release of (initial one option):
_____ All protected health information, OR
_____ The most recent two years of protected health information, OR
_____ Specific information ____

I understand that the Healthcare Provider needs my specific authorization to release information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case. (Initial all that apply. Leaving a space blank indicates that no information about the item is to be released.)

_____ HIV/AIDS test or result information and related records
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment or referral information

(continued on next page)

ODS Community Health, Inc.

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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.

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, please send a written statement to ODS Community Health, Inc., Privacy Office at 601 S.W. 2nd Avenue, Portland OR, 97204 and state that you are revoking this authorization.

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 the following (check one):

☐ Date: ________________________ (not to exceed 24 months), OR

☐ Event: ________________________

(The event will be limited to 24 months maximum.)

I have reviewed and I understand this Authorization.

Signed ________________________ Date ______________
(Individual)

-OR-

Signed ________________________ Date ______________
(Individual's representative)

Relationship to Member: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*
*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

INSTRUCTIONS: ALL RELEVANT FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID. MEMBER SHOULD RETAIN A COPY OF THE SIGNED ORIGINALS.

Mail the signed originals to: ODS Community Health, Inc.
Privacy Office
601 S.W. 2nd Avenue
Portland, OR 97204

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