PERMISSION TO USE AND SHARE PROTECTED HEALTH INFORMATION (PHI)

I allow Umpqua Health Alliance CCO and its partners to share PHI shown below to the people listed on this form.

Please print your information on this form to allow UHA to use it.

MEMBER INFORMATION	
Name of Member:	Email:
Member's Address (City, State, Zip):	
Daytime Telephone:	Date of Birth:
Member's ID Number:	

PEOPLE I ALLOW TO RECEIVE MY PERSONAL HEALTH INFORMATION (PHI)	
Name:	Relationship:
Address (City, State, Zip):	Authorization to change information as needed:
Phone:	Email:
Name:	Relationship:
Address (City, State, Zip):	Authorization to change information as needed:
Phone:	Email

TYPE OF INFORMATION

If the information shared has any of these types of records or information listed below, other laws protect these four areas. If I want this information shared I will place my initial in the space provided:

_____ HIV/AIDS Information (initials)

_____ Mental Health Information (initials)

_____ Genetic Testing Information (initials)

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

The information given in this form will not be protected by federal law. Other laws may limit the use of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

By signing this form, I allow UHA to share the PHI listed.

PERMISSION TO USE AND SHARE PROTECTED HEALTH INFORMATION (PHI)

MY RIGHTS

I understand I have the right not to sign this form. If I do not sign this form it will not affect my health plan with UHA.

I understand I have the right to cancel this permission in writing at any time. If I Cancel this permission, the information listed above will no longer be used. Any uses or information already given with my permission cannot be taken back.

Unless I cancel it, this form will be good for Two Years (24 months) from the date of my signature or until this earlier date ____/_____/____.

SIGNATURE

I accept that I have read this form and understand it.

* Signature:

Print Name:	Date:

Daytime Telephone:

*If I am not the member, I am:

☐ Parent***
☐ Legal Guardian***
☐ Health Care Power of Attorney***
☐ Health Representative***

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

***Children of the following ages must sign this form to release their PHI to any person or facility:**
14 years of age and above – Chemical Dependency
15 years of age and above – All other medical conditions

Please mail to: Umpqua Health Alliance
500 SE Cass St Suite 101
Roseburg, OR 97470
Or fax to: 5416776038 Attn: Customer Service