UMPQUA HEALTH ALLIANCE

PERMISSION TO USE AND SHARE PROTECTED HEALTH INFORMATION (PHI)

MEMBER INFORMATION:

Member Name		Date of Birth	
UHA ID Number		Phone Number	
Member Address (City, State, Zip)			
Email			

PEOPLE MEMBER ALLOWS TO RECEIVE PROTECTED HEALTH INFORMATION (PHI):

Name			
Phone		Relationship	
Member Address (City, State, Zip)			
Email	Date of Birth:		
Authorization to change information as needed (circle one): ☐ Yes ☐ No			
Name			
Phone		Relationship	
Member Address (City, State, Zip)			
Email	Date of Birth:		
Authorization to change information as needed (circle one): ☐ Yes ☐ No			

TYPE OF INFORMATION ALLOWED TO BE RECEIVED:

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 initials in the space provided:

	HIV/AIDS Information		Mental Health Information
	Genetic Testing Information		Drug/Alcohol Diagnosis, Treatment, and Referral Information

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.**

MEMBER 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 or coverage with UHA.
- 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 of information already given with my permission cannot be taken back.

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ACCEPT & SIGN

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

☐ I allow UHA to communicate with myself and persons listed on this form via mail as well as secure email when requested.

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

Signature		Date
Print Name		
Phone Number		
Unless I cancel this permission, this form will be good for ONE YEAR (12 Months) from the date of my signature or until this earlier date:_____/_____/_____.		
If I am not the Member, I am:	☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney ☐ Health Representative	

PLEASE NOTE:

- **If you are the legal guardian or holder of a health care power of attorney for the member, please attach legal documentation.**
  - **If possible, please include a photocopy of a valid driver's license or official ID for the person(s) you listed on the form.**
- **Children of the following ages MUST sign this form to release their PHI to any person or facility:**
- **14 years of age & above - Chemical Dependency**
- **15 years of age & above - All other medical conditions**

SUBMIT THIS FORM TO UHA CUSTOMER CARE BY ONE OF THE FOLLOWING OPTIONS:

- **Fax:** 541-677-6038
- **Email:** UHCustomerCare@umpquahealth.com
- **Mail:** 3031 NE Stephens St.
  Attn: UHA Customer Care
  Roseburg, OR 97471

Get this information in any language or format for free. All interpretation services are free. Call 541-229-4842 (TTY 711).

Obtenga esta información de forma gratuita en cualquier idioma o formato. Todos los servicios de interpretación son gratuitos. Llame al 541-229-4842 (TTY 711).