PacificSource Community Solutions, Inc.
PO Box 5729, Bend, OR 97708-5729
800.431.4135 Central Oregon
855.204.2965 Columbia Gorge
CommunitySolutions.PacificSource.com

Authorization to Use and Disclose Protected Health Information

This form is available in alternative formats including Braille, large print, computer disk, and oral presentation.

Si usted necesita servicios de intérprete, por favor llame al teléfono (800) 431-4135 si vive en Central Oregon o al teléfono (855) 204-2965 si vive en Columbia Gorge.

I hereby authorize PacificSource Community Solutions, 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 the form.

Member Information		
Member Name:	Date of Birth:	
Member Address:		
City:	State:	Zip:
Phone:	Member ID Number:	
Who is Authorized to Receive my Personal Health Information		
Name:		
Address:		
Phone:	Fax:	
Are the authorized person(s)/entities allowed to change my primary care provider?	☐ Yes	☐ No
Are the authorized people(s)/entities allowed to change my address?	☐ Yes	☐ No

Types of Information to be Released and How it Will be Used

If the information has any of the types of records or information listed below, additional laws relating to use and release may apply. I understand that this information will only be released if I put my initials in the space next to the information:

_____ (Initials)	HIV/AIDS Information	_____ (Initials)	Mental Health Information
_____ (Initials)	Genetic Testing Information	_____ (Initials)	Drug/Alcohol Diagnosis, Treatment, and Referral

I understand that the information used and released as stated in this authorization may be subject to re-release and no longer protected under federal or state law. I also understand that federal or state law does not allow re-release of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records, or referral information without specific authorization.

Information obtained with this authorization will be used for the purpose defined below and will be limited to the minimum necessary information.

Please also list any limitations you would like to place on the use of this information:

_____

_____

_____

Right to Cancel Authorization

I understand I have the right to cancel this authorization in writing at any time. If I cancel this authorization, the information described above will no longer be used or released for the reasons in this written authorization. Any uses or releases made with my permission cannot be taken back.

To cancel this authorization, I understand I must send a written and signed statement. Please mail to PacificSource Community Solutions, Inc., PO Box 5729 Bend, OR 97708-5729. You may also fax your request to (541) 322-6423.

Unless I cancel this authorization, it will remain valid for twenty-four (24) months from the date of my signature below, or earlier if requested.

Acknowledgement and Signature
By signing this form, I authorize PacificSource Community Solutions, Inc., its agents or subsidiaries, to release the following specific confidential information about me. I acknowledge that I have read this authorization and understand that the day I sign and date this form is when this authorization becomes effective. Signature: _____ Date: _____

Signature of Authorized Representative
Relationship to the Member: _____ Signature*: _____ Date: _____ Please provide <u>all</u> legal documentation proving your relationship to the member. Children of the following ages must sign the "Authorization to Use and Release Protected Health Information" form to release their personal health information to any person or entity: ***14 years of age and above – Chemical Dependency** ***15 years of age and above – All other medical conditions**

Please keep a copy of this form for your records.

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 replaces all prior versions.

Please mail or fax completed form to:

Mail: PacificSource Community Solutions, Inc.
P.O. Box 5729, Bend, OR 97708

Fax: (541) 322-6423