Providence
Medicare Advantage Plans

Enclosed is a Member Authorization form. Please complete the entire form, sign it and return it to Providence Medicare Advantage Plans.

Release of Member Information Requirements

Providence Medicare Advantage Plans is committed to protecting the privacy of our members. Occasions can and do arise when a loved one needs to assist with various decisions regarding a member's health insurance, financial arrangements, primary care physician selection and other matters. These occasions are typically the result of a member's failing health or declining mental state. To better serve the needs of our Providence Medicare Advantage Plans members and their families; please be advised of our policy regarding the disclosure of member information.

Providence Medicare Advantage Plans will not release member information to family and friends without having one (or more) of the following active forms on file:

- ☐ A copy of a legal document indicating a court appointed legal guardian or conservator.
- ☐ Power of Attorney for Healthcare and Directive to Physicians.
- ☐ Member Authorization form (attached).
- ☐ A copy of a General Power of Attorney (with specific language that allows the designee to make changes or obtain information).

Due to variations in content, the above documents do not guarantee your loved ones the same access to information and decision-making power as the member or the member's legal guardian.

You may send your Member Authorization form to Providence Medicare Advantage Plans at:

Providence Medicare Advantage Plans
PO Box 5548
Portland Oregon 97228-5548

You may fax your Member Authorization form to 503-574-8608 or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Medicare Advantage Plans
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

Please Note: The enclosed form must be completed, signed and dated.

If you have any other questions or concerns, you may contact the Providence Medicare Advantage Plans Customer Service Team at 503-574-8000 or 1-800-603-2340. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you,

Providence Medicare Advantage Plans

MEMBER AUTHORIZATION FORM

By completing the Member Authorization form, you are telling Providence Medicare Advantage Plans that you chose the named person in Part B below and this form allows Providence Medicare Advantage Plans to disclose your Protected Health Information (PHI) and Personally Identifiable Information (PII) to the person you choose.

Part A. Information about the member whose healthcare information will be disclosed.

Part B. Name of the person or company you are authorizing to receive your PHI/PII.

Part C. The reason for your authorization? For the personal use of the member, for a specific reason or event or for a legal purpose.

Part D. Tell us what information may be disclosed.

> ***All Information:*** Check if authorizing "all PHI" as listed to be shared with the person or company listed in PART B except for Sensitive Health Information.
>
> ***Or***
>
> ***Only the information specified:*** Check each item you are authorizing.

Part E. Tell us what sensitive information may be disclosed.

> **Sensitive Health Information:** Please note that you will need to place your initials next to the Sensitive Information if you wish to authorize release of this information.

Part F. You may allow the person in PART B to perform administrative functions on your behalf.

Part G. Date your Authorization Expires

Part H. You have the right to revoke your authorization and you understand what you have authorized.

Part I. Your Approval (signature & date)

MEMBER AUTHORIZATION FORM

Use this form to authorize Providence Medicare Advantage Plans to use or to disclose your health information to another person or company. The Authorization Form must be completed in full for it to be valid. Please complete the following information exactly as it appears on your member identification (ID) card.

PART A: MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number** (See your member ID card)	**Group Number** (See your member ID card)
Member Home/Street Address	**City and State, Zip Code**	**Preferred Phone #**

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following person(s), facility or company have the right to receive my protected health/personal information. (They must be 18 years of age or older). Please fill in the below:

Recipient's Name: ____

Relationship to Member: ____
(Spouse/Domestic Partner/Friend/Caretaker/Broker/Other)

PART C: THE REASON FOR MY AUTHORIZATION (check one):

☐ Personal Use
☐ Only for this reason/event(s): ____
(Only applies for a specific reason or event, an example might be to settle a claim or a one-time release)
☐ Legal Purpose

PART D: INFORMATION THAT CAN BE RELEASED BY PROVIDENCE MEDICARE ADVANTAGE PLANS

I allow the following information to be disclosed by Providence Medicare Advantage Plans on my behalf to the person in PART B.

☐ **All Information (as listed to the right):**
Check if authorizing all PHI to be shared with the person or company listed in Part B above except for Sensitive Health Information. **(Please note that you still need to initial the boxes for sharing any Sensitive Information if you wish to authorize release of this information.)**

Only the information specified below:
(Please check each one that applies):
☐ Eligibility/Benefits
☐ Enrollment
☐ Claims Information
☐ Clinical Notes
☐ Medical Information (diagnosis, treatment, medication)
☐ Premium Information/
Resolve Billing Questions/Problems
☐ Referrals and Authorization of Medical Services

PART E: I ALSO APPROVE THE RELEASE OF SENSITIVE INFORMATION

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply.

*I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand and agree that the below information will only be disclosed if I **place my initials** in the applicable space next to the type of information.

______ AIDS or HIV

______ Alcohol/Drug/Substance Abuse (diagnosis, treatment or referral information)*

______ Genetic Information (services or tests)

______ Maternity/Pregnancy (reproductive health)

______ Mental Health Data and Records

______ Sexually Transmitted Illness/Disease (testing and treatment)

PART F: PERMISSION TO ACT ON MY BEHALF

☐ To perform **EVERY ACT** listed below

OR

To perform **ONLY** those acts ***check marked below***:

- ☐ Request a new ID card
- ☐ Change my Address
- ☐ Inquire/Choose/Change my Primary Care Physician
- ☐ Enroll/Disenroll me from the Plan
- ☐ Correct Missing/Erroneous Demographic Information (age, gender, marital status, race)

PART G: DATE YOUR AUTHORIZATION EXPIRES: (check one):

Please check the below **expiration date** you wish to have for this authorization:

☐ **Maximum** allowed time of **12 months** from the date of signature

☐ Other Date/Event listed here: (**Only If** less than 12 months)

____

If there is no earlier expiration date/event indicated, this authorization shall be in force and in effect until it expires 12 months from the date of signature

PART H: REVOCATION AND REVIEW

I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization, except to the extent that Providence Medicare Advantage Plans already has already acted in reliance on my Authorization. Any uses or disclosures already made with my Authorization cannot be taken back. To revoke this Authorization, please send a written statement to Providence Medicare Advantage Plans at P.O. Box 5548, Portland, OR 97228 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include your name, ID# and date of birth, the name of the person(s) whom you would like to revoke from receiving your protected health information.

The revocation will be effective immediately upon Providence Medicare Advantage Plans' receipt and processing of your written statement. **Please note:** that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be done in writing.

I have read the contents of this authorization. I understand, agree, and allow Providence Medicare Advantage Plans to use and disclose my information as I have stated above. I also understand that signing this authorization form is of my own free will. I understand that Providence Medicare Advantage Plans does not require that I sign this authorization form in order for me to receive treatment, payment, or for enrollment or being eligible for benefits. 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.

PART I: APPROVAL MEMBER (SIGNATURE AND DATE)

By: ____ Date: ______________

(Member Signature)

– OR –

By: ____ Date: ______________

(Member's Designated Legal Representative/Guardian Signature)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

***If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.**

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Providence
Medicare Advantage Plans

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-603-2340 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。