MEMBER AUTHORIZATION ALLOWING OEA CHOICE TRUST TO USE/DISCLOSE PROTECTED HEALTH INFORMATION TO ANOTHER PERSON/ENTITY

Member: ____

ID#: ____________________ Date of Birth: ____________________

Group Name: ____________________ Group #: ____________________

I authorize ☐ OEA Choice Trust to use and disclose a copy of my protected health information to:

____

(Name and address of recipient or class of recipients)

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

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

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

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 OEA Choice Trust, Privacy Office at 6900 SW Atlanta Street, Building 2, Tigard OR 97223 and state that you are revoking this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure 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 remain in effect until the following (check one):

☐ Date: ______________________________ (not to exceed 24 months), or

☐ Event: ______________________________

I have reviewed and I understand this Authorization.

By:______________________________ Date: ______________
(Individual)

-or-

By: ______________________________ 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.*

All fields must be completed for this Authorization to be valid.

Member must be given a copy of the completed form.

Mail the signed original to:

OEA Choice Trust
Privacy Office
PO Box 23600
Tigard OR 97281-3600