Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #

Individual's Street Address	City	State	Zip Code

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying PBH in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize PBH and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

_____

(Full Name of Person(s) or Organization(s))

_____

(Full Address of Person(s) or Organization(s))

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

☐ I authorize only the disclosure of the following information:

_____

(Type of Information)

Purpose of Disclosure:

- ☐ My health information is being disclosed at my request or at the request of my personal representative; **or**
- ☐ My health information is being disclosed for the following purpose:

____
(Explain Purpose)

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________________________________ ______________
Signature of Individual Date

________________________________ _______________
Witness Signature *(For Illinois Residents Only)* Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

________________________________ ___________________________
Signature of Individual's Representative Date

Personal Representative's:

_________________________ _______________
Name Phone Number

_________________________ _______________ __ ___________________
Street Address City State Zip Code

(*For California and Georgia residents only*) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

INSTRUCTIONS FOR RETURNING THIS FORM:

By Mail: Mail the completed form to the following address:

PBH (UBH)
ATTN: Records Management
7632 SW Durham Rd, Ste 300
Tigard, OR 97224

By Fax: Fax the completed form to one of the following phone numbers:

Toll Free Confidential Fax	(866) 720-3872
Confidential Fax	(503) 603-3180