Authorization to Release Personal Health Information

I, ___________________________, give the following person(s) permission to contact Health Share of Oregon on my medical behalf. I give permission to Health Share of Oregon to discuss personal information, including address, phone number, member ID number, plan information, and effective dates in order to verify information and/or make any necessary updates and changes.

Please fill out (print) the following lines.

____

(Name) (Relationship)

____

(Name) (Relationship)

I understand that I am not giving permission for any discussion of my information other than reasons listed above. I understand that Health Share of Oregon may only speak with the above listed person(s) unless another form is completed or such information is specifically required by law.

I understand that this form is for use by Health Share of Oregon only and I may be required to submit additional releases to other organizations involved in my healthcare.

This release is effective for one (1) year from the date it is signed.

X ____

Member Signature Date

____

Member's Oregon Health Plan ID

X ____

Signature of Parent, Guardian or Legal Representative if member is a minor (state your relationship to the patient) Date

Please return this document to Health Share of Oregon one of the following ways:

Fax: 503-459-5749
Email: info@healthshareoregon.org
Mail: 2121 Sw Broadway, Ste 200, Portland, Or 97201

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