Authorization for Disclosure of Protected Health Information (PHI)

Jackson Care Connect™
Part of the CareOregon Family

Information about you and your health, called Protected Health Information (or "PHI"), is sensitive. Health plans, such as Jackson Care Connect, may not use this PHI or disclose it to anyone unless you say it's OK in writing. This form gives your consent to use and disclose your PHI. You must fill out everything marked with a star (*) for this form to be valid.

Member information

My name (Please print member's name:)_____

***My date of birth** (or Jackson Care Connect ID):_____

***I give my consent to Jackson Care Connect to use my PHI and disclose it to:**

***Individual or organization:** _____

Address: _____

City:_____

State:_____

ZIP:_____

Phone number: _____

Relationship to member:_____

I am asking for my PHI to be used or disclosed because (list reasons):_____

_____

☐ **I am specifically asking for such disclosure and choose not to provide a specific reason**

***My PHI to be disclosed includes:** ◉ All of it, **OR** ○ Only the items I've checked below:

☐ **Prior authorizations**
☐ **Billing records**
☐ **Claims**
☐ **Medications**
☐ **Health plan records**
☐ **Benefits**

☐ **Other** (Please describe what specific information/documents you are asking for):

_____

_____

Dates from: _____ **to:** _____

Event (optional):_____
(for example, if you went to the hospital in June 2011)

Other information that I authorize to be disclosed: The three kinds of PHI listed below are protected by other laws. It is OK for Jackson Care Connect to disclose this PHI only if I've initialed the space beside it on this form. If I haven't initialed it here, Jackson Care Connect may not disclose it.

Initials	Type of PHI
	Anything about an HIV/AIDS test, including whether I've taken one, the results of a test and other records about it.
	Any of my mental health information (excluding psychotherapy notes).
	Any information about drug or alcohol diagnoses, treatment or referrals. (I also understand that federal law says no one who gets drug or alcohol information from Jackson Care Connect can disclose it to anyone else unless I also give my written authorization to them).

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I understand my rights about this consent form:

- I can ask for someone from Customer Service at Jackson Care Connect to help me understand how this form will be used.
- I know that if the individual or organization that receives this PHI is not a health care provider or health plan covered by federal privacy laws, they might share the PHI listed above. In that case, my PHI won't be protected under those laws.
- I know that social media platforms (such as Facebook, Instagram, Twitter, Pinterest, etc.), are not secure places to share health information. My participation in groups, acceptance of invitations, submission of content or comments, etc., on social media platforms are not protected by federal privacy laws.
- I may see or get a copy of any PHI that will be given out because I've signed this form.
- I don't have to sign this form to get health care, to have my health care paid for, to learn if I am eligible for benefits or to enroll in Jackson Care Connect.
- I can revoke this authorization in writing except when Jackson Care Connect has already acted in reliance on it.
- I can change my mind and cancel my permission at any time. If I do change my mind, I must let Jackson Care Connect know in writing by sending a letter to:

  Attn: Enrollment Department
  Jackson Care Connect
  315 SW Fifth Ave
  Portland, OR 97204

  If I change my mind and cancel this consent, I understand that my PHI may have already been used or given out.

My consent to disclose PHI is limited

Unless I change my mind and sign a new written authorization, my consent to disclose PHI will stop on the following date (check one):

- (•) 365 days from the date that I sign this form,
- ( ) When this event occurs (list specific event) _____
- ( ) Or, on this date (list specific date or write out "no end date"): _____

I may ask for a copy of this form for my records after I sign it.

*My signature: _____

Date: _____

My printed name: _____

**If anyone signs for the member, please provide a copy of Power of Attorney or other legal document giving that permission.*

Fax completed form to:
503-416-3723

OR

Mail to:
Enrollment Department
Jackson Care Connect
315 SW Fifth Ave
Portland OR 97204

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