Authorization to Disclose Protected Health Information

PacificSource Administrators, Inc.
Attn: Customer Service
P.O. Box 70168
Springfield, OR 97475
www.pacificsource.com/PSA

INSTRUCTIONS FOR COMPLETING AUTHORIZATION FORM

We understand that you may wish us to communicate with others about your healthcare. As you may be aware, certain information regarding your health is protected by state and federal law to help ensure your privacy. We therefore cannot disclose your protected health information without your written authorization.

If you wish to grant a person or entity legal permission to access your protected health information (for example, FSA or HRA Plan Claim transactions), please complete the enclosed form, our Authorization to Disclose Protected Health Information.

The following guidelines will help you complete the form correctly.

- **Member name** is the name of the specific person whose protected health information is to be released.
- **ID number** is the member ID. The Member should have received a letter with this ID when they enrolled. You may call Customer Service if you need help locating this information.
- **Employer Name: Please list the name of your current Employer.**
- **"Recipient or class of recipients"** simply means the name and address of the person(s) you wish to have access to your protected health information.
- **Expiration date** is the date you wish your authorization to end. After that date, we do not have your permission to use or disclose your protected health information.
- **Event**: Instead of an expiration date, you may specify an event after which we do not have your permission to disclose your protected health information.
- **Signature**: The person whose protected health information is to be released must sign the form in order for the authorization to be valid. If the person is a minor child, their parent or legal guardian may sign for them. If the person is unable to sign for themselves, someone with their Power of Attorney may sign for them. In the case of legal guardians and Holders of Power of Attorney, legal documentation must be attached.
- When the form is complete, you may fax it to us at (800) 575-1109 or mail it to: **PacificSource Administrators, Inc., Attn: Customer Service, PO Box 70168, Springfield, OR 97475**.

We are very serious about protecting the personal health information of all our members. We appreciate your cooperation and assistance in helping us comply with state and federal regulations.

If you have any questions or concerns, you are welcome to contact our Customer Service Department by toll-free phone at (800) 422-7038

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

All fields must be completed to be valid.

Member Name: ____ **ID No.:** __________________________________

Employer Name: ____

I authorized *(person/entity disclosing information)* PacificSource Administrators, Inc. 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, for example: for all inquiries on FSA or HRA Plan Claim transactions)*:

____

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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 solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

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, unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I have the right to revoke this authorization in writing at any time. If I revoke your authorization, the information described above will no longer be 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, send a written statement that you are revoking this authorization to our Customer Service Department at PacificSource Administrators, Inc., PO Box 70168, Springfield, OR 97475.

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. **Unless revoked, this authorization will be in force and effect until *(check one)*:**

☐ Expiration Date: _______________________________ *OR* ☐ Event: ____

At which time this authorization to disclose this protected health information expires. Neither the specified date nor event shall exceed a period of 24 months.

I have reviewed and I understand this authorization.

Signature: ____ Date: ___________________________________

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

**Please attach legal documentation if you are the legal guardian or holder of power of attorney.*