Release of Member Information Requirements

Summit Health is committed to protecting the privacy of our members. Occasions can and do arise when a loved one needs to assist with various decisions regarding a member's health insurance, financial arrangements, primary care physician selection and other matters. To better serve the needs of our Summit Health Medicare Advantage plan members and their families; please be advised of our policy regarding the disclosure of member information.

Summit Health will not release member information to family and friends without having one (or more) of the following active forms on file:

- Member PHI Disclosure Authorization form (enclosed)
- Legal document stating legal representation of the member which may allow for the discussion of health care coverage, treatment, and payment. Legal documents include any one of the following:
  - Court appointed Legal Guardian or Conservator
  - General Power of Attorney
  - Power of Attorney for Healthcare

Due to variations in content, the above documents do not guarantee your loved ones the same access to information and decision-making power as the member or the member's legal representative.

Please complete the form, sign and date, and mail, email, fax or deliver to the Summit Health Privacy Department at:
Summit Health Plan, Inc. Attn: Privacy Department
601 SW Second Ave, Portland, OR 97204

You may fax your Member PHI Disclosure Authorization form to 503-412-4068
You may email your Member PHI Disclosure Authorization form to Privacy@YourSummithealth.com

Please Note: The enclosed form must be completed, signed, and dated.

Member Protected Health Information Disclosure Authorization Form

SUMMIT HEALTH

Use this form to authorize Summit Health Medicare Advantage Plan to use or to disclose your health information to another person or company. The Authorization Form must be completed in full for it to be valid. Please complete the following information exactly as it appears on your member identification (ID) card.

Section 1 Member information
Information about the member whose healthcare information will be disclosed.

Member last name	Member first name	Middle initial
Member date of birth	Member identification #	Group #

Section 2 Person or Company who will receive this information
Name of the person or company that you will authorize Summit Health to share information with

The following person(s), facility or company have the right to receive my protected health/personal information. (They must be 18 years of age or older). Please fill in the line below:

Recipient's full name: _____

Section 3 The reason for my authorization

Check one:

- ○ Discussing information related to my health coverage, treatment, and payment
- ○ Only for this reason/event(s): _____

  (Only applies for a specific reason or event, an example might be to settle a claim or a one-time release)
- ○ Legal Purpose

Section 4 Information that can be released by Summit Health

I allow the following information to be disclosed by Summit Health on my behalf to the person in Section 2.

☐ All Information (as listed to the right):

Check if authorizing all PHI to be shared with the person or company listed in Part B above except for Sensitive Health Information if you wish to authorize release of this information.)

Only the information specified below:

(Please check each one that applies)

- ☐ Eligibility/Benefits
- ☐ Enrollment
- ☐ Claims Information
- ☐ Clinical Notes
- ☐ Medical Information (diagnosis, treatment, medication)
- ☐ Premium Information/Resolve Billing Questions/Problems
- ☐ Referrals and Authorization of Medical Services

Section 5 I also approve the release of Sensitive Information

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply.

* I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand and agree that the below information will only be disclosed if I **place my initials** in the applicable space next to the type of information.
Please note: The signature of a minor is required to authorize Summit Health to release certain sensitive health information pertaining to the minor.

____AIDS or HIV

____Alcohol/Drug/Substance Abuse (diagnosis, treatment or referral information)*

____Genetic Information (services or tests)

____Maternity/Pregnancy (reproductive health)

____Mental Health Data and Records

____Sexually Transmitted Illness/Disease (testing and treatment)

Section 6 Date your authorization expires

Please check the below **expiration date** you wish to have for this authorization (check one):

○ **Maximum** allowed time of **24 months** from the date of signature

○ Other Date/Event listed here: (Only if less than 24 months)

_____

If there is no earlier expiration date/event indicated, this authorization shall be in force and in effect until it expires 24 months from the date of signature.

Section 7 Revocation and Review

I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization, except to the extent that Summit Health already has acted in reliance on my Authorization. Any uses or disclosures already made with my Authorization cannot be taken back. To revoke this Authorization, please send a written statement to:

Summit Health Plan, Inc.
Attn: Privacy Department
601 SW 2nd Ave
Portland, OR 97204

State that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include your name, ID# and date of birth, the name of the person(s) whom you would like to revoke from receiving your protected health information.

The revocation will be effective immediately upon Summit Health receipt and processing of your written statement. *Please note: that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be done in writing.*

I have read the contents of this authorization. I understand, agree, and allow Summit Health to use and disclose my information as I have stated above. I also understand that signing this authorization form is of my own free will. I understand that Summit Health does not require that I sign this authorization form in order for me to receive treatment, payment, or services. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure 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.

Section 8 Member/Legal Representative Signature and Date

By: _____ Date:_____

(Member Signature)

-OR-

By: _____ Date:_____

(Member's Designated Legal Representative/Guardian Signature)

Relationship to Member:

- ○ Parent
- ○ Legal guardian*
- ○ Holder of Power of Attorney*

* **If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or holder of Power of Attorney.**

* Note: To parents/legal guardians of minors: state laws may prohibit Summit Health from acting on your request about Sensitive Information without authorization from the minor member. (Both parent and minor must sign)

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Additional permissions and actions

Additional actions outside of the sharing of PHI may be completed on behalf of a member upon request. For an individual other than the member to make the changes listed below, valid legal documentation such as a Power of Attorney must be on file with Summit Health or accompany the request.

A signed and completed PHI Authorization Form alone will not suffice.

Additional Permissions and Actions

- Request a new ID card
- Change my Address
- Change Phone Number
- Change Email Address
- Inquire/Choose/Change my Primary Care Physician
- Enroll/Disenroll me from the Plan
- Correct Missing/Erroneous Demographic Information (age, gender, marital status, race)