



HEALTH  
INSURANCE  
PROGRAM

P.O. Box 40187, Portland, Oregon 97240-0187  
(503) 224-7377 or 1-800-768-7377

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

**PERS Member Name:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**I authorize:** Representatives of The PERS Health Insurance Program and health plan ( \_\_\_\_\_ )  
to **obtain and disclose my Protected Health Information to:** \_\_\_\_\_ Name of health plan

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**For the purpose of:**

The information may include any of the following elements: Verification of retirement date and years of PERS pension service, Health Plan enrolled in, Date of enrollment/dis-enrollment with health plan, Billing and Premium information. Information obtained or disclosed with this authorization for the purpose defined above will be limited to the minimum information to achieve the purpose.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be disclosed for the reasons covered by this written Authorization except to the extent action has been taken with reliance on this Authorization. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected under federal law.

**This authorization shall be in force and in effect until the following date OR event:**

**Date:** \_\_\_\_\_ (Not to exceed 24 months)      **Event:** \_\_\_\_\_  
(Describe event)

**I have reviewed and I understand this Authorization:**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(PERS Member)

**- OR -**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(PERS Member's Representative)

Relationship to member: \_\_\_ Parent    \_\_\_ Legal Guardian\*    \_\_\_ Hold Power of Attorney\*

\*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

*All fields must be completed for this authorization to be valid.*

In the Portland area call: (503) 224-7377 or toll free at: 1-(800)-768-7377  
The Portland area FAX is: (503)-765-3452 or toll free FAX: 1-(888)-393-2943  
*Member must be given a copy of the completed form.*

**To revoke this Authorization, please send a written statement to:**

PERS Health Insurance Program • Attention Privacy Office  
PO BOX 40187 • Portland, OR 97240-0187