



HEALTH  
INSURANCE  
PROGRAM

### AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

**Purpose:** This authorization allows the PERS Health Insurance Program and/or your health plan to discuss your retirement date and years of PERS pension service, health plan enrollment, date of enrollment, disenrollment with your health plan, billing and premium information with the individual identified below.

Each person enrolled who wants to share this information must complete a separate authorization. Additional authorization forms may be found on the PERS Health Insurance Program website (www.pershealth.com).

**I authorize:** Representatives of The PERS Health Insurance Program and health plan:

- ODS Health Plan, Inc.
- Kaiser Permanente
- PacificSource
- Request Providence-specific PHI form

to **obtain and disclose my Protected Health Information to:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**For:** The information disclosed 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:**

**Date:** \_\_\_\_\_ (Not to exceed 24-months from the signature date.)  
(If the date field is left blank, the authorization will expire 24-months from the signature date).

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

PERS Health Insurance Program Member: Name \_\_\_\_\_ SSN# \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**- OR -**

PERS Health Insurance Program Member's Representative: Name \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.*

**Member must keep the yellow copy of the completed form.**

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

Attention Privacy Office • PO BOX 40187 • Portland, OR 97240-0187