Protected health information disclosure authorization

When completed, this form signifies member authorization allowing the disclosure of protected health information to another person/entity. To expedite your authorization, please print legibly in black or blue ink and return as instructed. **Please complete all sections of this form and provide your signature on page 2. Incomplete or unsigned forms cannot be processed.**

Member (Patient) Information

Name | Date of birth (mm/dd/yyyy) | ID no.

Employer name | Group no.

Authorization

I understand that in connection with the provision of services to me, Ardon Health has certain protected health information pertaining to me. I authorize Ardon Health to use and disclose a copy of my protected health information to:

Name | Relationship

Address | City | State | ZIP

For the purpose of (select one):

☐ Discussing all information related to my insurance coverage, treatment and payment.

☐ Other (please specify purpose): _____

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

Additional laws relating to use and disclosure of the information apply if the information disclosed contains any of the types of records or information listed below. I understand that information disclosed pursuant to this authorization may include the following categories of information, to the extent such information is contained in my records and disclosure is permitted by applicable law.

- HIV/AIDS test or result information and related records
- Drug/alcohol diagnosis, treatment, or referral information
- Reproductive health
- Genetic testing information
- Mental health information

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.

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 used or 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, please send a written statement to: Ardon Health, Privacy Office at PO Box 20338, Portland, OR 97294 and state that you are revoking this authorization.

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. 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.

Unless revoked, this authorization shall be in force and effect until the following **(select ONE option only)**:

☐ Date: _____ (not to exceed 36 months from the date of signature)*

or

☐ Event: _____
(The event will be limited to 36 months maximum. **Do not** list events such as "Death," "Termination of Policy" or "Until Revoked." Such events will result in the return of this authorization as invalid).

Ardon Health will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except where permitted by law.

By signing below, I agree that I have reviewed and I understand this authorization

Signature of individual

X _____

Signature date

_____

or

Signature of individual's representative

X _____

Signature date

_____

Print name of representative

_____

Relationship**

_____

*If a date is not submitted (left blank), the authorization will be limited to 36 months from the date of signature.

**Please attach legal documentation if you are the legal guardian, legal custodian or holder of Power of Attorney or have other legal authority for the member.

All fields must be completed for this authorization to be valid. Member should retain a copy of the completed form.

Please return your signed form to Ardon Health using the enclosed prepaid envelope.

Or return to us via mail or fax.
Mail: Ardon Health Specialty Pharmacy, PO Box 20338, Portland, OR 97294
Fax: 855-425-4096