Health Net Health Plan of Oregon, Inc. (Health Net)

Authorization to Use and Disclose Health Information

NOTICE TO MEMBER:

- Completing this form will allow Health Net Health Plan of Oregon, Inc. (Health Net) to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Health Net will not change if you do not sign this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of page 2. A revocation form can be provided to you by calling Customer Contact Center at 888-802-7001 (TTY: 711) or visit our website at healthnetoregon.com.
- Health Net cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. The form will not be valid if incomplete. When finished, mail, fax or email the form using the information at the bottom of page 2.

Member information

Member name (print):	
Member date of birth:	Member ID number:

I give Health Net permission to use my health information for the purpose identified or to share my health information with the person or group named below. (You may choose one or both boxes.) The purpose of the authorization is:

☐ **to allow Health Net to help me with my benefits and services, or**

☐ **to permit Health Net to use or share my health information for** _____.

Person or group to receive information (add additional persons or groups on page 2)

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:

I authorize Health Net to use or share the following health information (please choose one)

☐ **All of my health information (INCLUDING** genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records **(please specify any substance use disorder information that may be disclosed)**:

_____); **OR**

☐ **All of my health information EXCEPT (check all boxes that apply):**

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Behavioral health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

Authorization end date

By signing this authorization, I acknowledge that I have read and understand the information provided on this form, and that my signature authorizes the disclosure of the information described above.

Authorization end date (Please choose a date or event within two years. This form is not valid if this box is blank.):

Member signature (member or legal representative sign here):	Date:

If you are the member's personal representative, please send us copies of those forms (such as power of attorney or judgment of guardianship).

Additional individual person(s) or entity(ies) to receive information

NOTE: If you want to disclose records of substance use evaluation or treatment, specify the name of the individual or provider to whom you want us to disclose those records.

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:
Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:
Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:
Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:
Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:

Mail completed form to:

Health Net, PO Box 11756, Eugene, OR 97440-3956

Fax: 844-426-5340

Email: PMyInfo@trilliumchp.com

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