HARRISON TRUST

A Family Health Plan

www.harrison.aibpa.com

AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my protected health information as described below. My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

In order to process your request to release your Protected Health Information, please complete the following information and return this form to:

Client Services
Harrison Trust
1220 S.W. Morrison St., Suite 300
Portland, OR 97205

Please contact us at (503) 224-0048, ext. 1679 or (800) 547-4457, ext. 1679 if you have any questions.

INDIVIDUAL DATA:

PARTICIPANT'S NAME:____

NAME OF GROUP HEALTH PLAN: __________________________________

GROUP HEALTH PLAN ID NUMBER OR SOCIAL SECURITY NUMBER:

____

DATE OF BIRTH: ____

ADDRESS: ____

TELEPHONE NUMBER: ____

Relationship to Employee: ☐ Self ☐ Dependent

If you are a covered dependent, please provide the employee information below:

Employee Name: ____

Employee Plan ID Number or Social Security Number:________________________

The following individual, organization, or class of persons (*e.g.*, group of individuals within the organization) is authorized **to use or disclose** my protected health information:

____

____

The following individual, organization, or class of persons is authorized **to receive** my protected health information:

____

____

The protected health information that may be used and disclosed is as follows:

____

____

[Describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

My protected health information will be used or disclosed for the following purpose(s):

____

____

[Describe the reason for each use and disclosure of the protected health information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual."]

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to Harrison Trust Client Services at 1220 SW Morrison, STE 300, Portland OR 97205, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information the Harrison Trust already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the Harrison Trust and, by law, the Harrison Trust has a right to contest the coverage.

This authorization expires [identify a specific date or event] :________________________

____

Participant Name (Print or Type)

____

Employee Name, if different than Participant Name (Print or Type)

____

Name of Personal Representative (if applicable)

____

Signature of Participant or Personal Representative Date

____

____

Description of Personal Representative's Authority and Telephone Number