AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

You can use this form to give permission to Aspire Health Plan to share your personal health information with a trusted person or organization you select. Please complete, sign and return this form to: Aspire Health Plan
PO Box 5490
Salem, OR 97304

How long does this permission last? Permission to share your records will remain valid for twenty-four (24) months from the date of my signature below or until ____/_____/____ (if desired, insert an earlier date).

Can I change my mind and "take back" this permission? You can tell us to stop sharing your information in the future. However, it's not possible to "take back" information we've already shared.

How do I end permission to share my personal health information? You will need to write to us to request an end to your permission. Be sure to sign and date it. You can mail or fax your request. Please keep a copy for your records.

What happens to my health information after Aspire Health Plan shares it? We can't control what happens to your information after we share it with the person or organization you name on this form. At that point, HIPAA or federal privacy laws may not protect your information. It could be shared with others.

Member Information (Required)

Member First Name_____ Member Last Name _____

Member ID_____ DOB ____/____/_____ Phone _____

I am allowing access to disclose the following:

- ☐ All personal healthcare information
- ☐ Billing and Claims information
- ☐ Provider/PCP Information
- ☐ Health Related Information
- ☐ Mental Health Related Information
- ☐ Enrollment and Demographic Information or Changes

Information above may be disclosed to the following individual(s):

Name of Person who can receive the above information	Date of Birth	RELATIONSHIP (spouse, child, etc.)	Telephone Number

SIGNATURE OF **MEMBER** (BENEFICIARY)		TODAY'S DATE
STREET ADDRESS		
CITY	STATE	ZIP

I understand that the Plan may not control my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization. I understand that I have the right to revoke this authorization at any time by sending a letter to Aspire Health Plan.

If you have any questions, please call Aspire Health Plan Member Services Department at toll free (855) 570-1600. TTY users should call 711. We are open 8:00am – 8:00pm PST Monday through Friday (except holidays) from February 15th to October 14th and 8:00am – 8:00pm PST seven days a week for the period of October 15th through February 14th.

Aspire Health Plan is an HMO plan with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal.