AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You can use this form to give permission to Aspire Health Plan to access your benefits and coverage, your claims and/or your bills and to share your personal health information with a trusted person you select. Please complete, sign and return this form to:

Aspire Health Plan
PO Box 5490
Salem, OR 97304

Can I use this form to appoint a representative to file an initial request for coverage, a grievance or an appeal? You cannot. To file an initial request for coverage, a grievance or an appeal, you must complete a separate Appointment of Representative form (CMS-1696).

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 you name on this form. The person you give permission to may "re-disclose" this information, and in some cases, this information is not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving your health information from making further disclosure of it unless another authorization for such disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.

Can I have a copy of the information being requested? If you provide us with a written request, you may obtain or inspect a copy of the health information that you are asking us to share with the person you list on this form.

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 (includes all options below)

☐ Health Related Information
☐ Billing and Claims information
☐ Provider/PCP Information
☐ Alcohol/Drug Treatment Information
☐ HIV Test Results
☐ Mental Health Treatment Information
☐ Enrollment and Demographic Information or Changes

Information above may be disclosed to the following individual:

Name of Person Who Can Receive Information	**RELATIONSHIP (spouse, child, etc.)**	**DOB**	**Telephone Number**	**Address**

* Complete a separate form for each individual you wish to disclose your health information to.

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. Your revocation will take effect upon receipt of this letter, except to the extent that other have acted in reliance upon this Authorization. This authorization will expire upon termination of enrollment in 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.

Aspire Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.