Section K Authorization To Disclose Protected Health Information (PHI) *(optional)*

Purpose: This authorization allows the PERS Health Insurance Program (PHIP) to discuss your **retirement date and years of PERS pension service, health plan enrollment, date of enrollment, disenrollment with your health plan and billing/premium information** with the individual identified below. Each person enrolled who wants to share this information must complete a separate authorization. You can find more authorization forms at pershealth.com. ***You must complete all fields below.*** This authorization does not provide the same rights afforded with Power of Attorney documentation.

I authorize: Representatives of the PERS Health Insurance Program and my health plan:

☐ Moda Health Plan, Inc. ☐ Kaiser Foundation Health Plan of the NW ☐ UnitedHealthcare®

☐ Providence Health Assurance *(Additional PHI forms may be required by your selected health plan)*

To obtain and disclose my Protected Health Information (PHI) to:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose defined above.

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 disclosed for the reasons covered by this written authorization. Any previously disclosed information made with my permission cannot be taken back and may be subject to redisclosure and no longer protected by federal law.

This authorization shall be in force and in effect until the following date: _____
Not to exceed 24-months from the signature date. If the date field is left blank, the authorization will expire 24-months from the signature date.

I have reviewed and understand this authorization:

PHIP Member Name	SSN and/or PERS ID#
Signature X	Today's Date

OR

PHIP Member's Representative Name*	
Address	Phone #
Signature X	Today's Date
Relationship to Member: ☐ Parent ☐ Legal guardian ☐ Power of Attorney	

**Please attach legal documentation if you are the legal guardian or Power of Attorney.*

To change or revoke this authorization, please send a written statement to:
PERS Health Insurance Program, P.O. Box 40187, Portland, Oregon 97240-0187