ArrayRx PO Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

Disclosure Directive

This form directs ArrayRx to communicate with you about your personal health information at the address you select.

1. Member information

First Name	Last Name	
Member ID	Group Name & Number (check one) ☐ PEBB – 10008217 ☐ SEBB – 10016720	Date of Birth (MM/DD/YYYY)
Address	City/State	Zip code
Phone	Email	

2. Information that will not be disclosed includes, but is not limited to, the following:

- Domestic violence
- Gender affirming care
- Gender dysphoria
- Mental health
- Reproductive health
- Sexually transmitted diseases
- Substance use disorder

3. Alternate address

☐ Use the address in section 1
☐ Use the address below until I revoke or terminate this directive.

Address	City/State	Zip code

4. Please read this before you sign and spend

This Disclosure Directive does not apply to your health care provider. You must give them separate, specific instruction about what health care information they may share, and with whom. This request stays in effect until you notify us in writing that it is terminated or revoked. Your health plan may have already shared health information before it received this request, and that disclosure cannot be changed. Your health plan and its representatives are not required to comply with this request if a court order or court document prohibits us from following your directive. We will act upon your request within three business days of receiving it from you. You may also call us at 1-888-361-1611 (TRS: 711) to provide us with this direction.

5. Signature

Signature	Date

Mail to:

ArrayRx
601 SW 2nd Avenue
Portland, OR 97204
Fax: 1-800-207-8235

(2/5/2025)