ArrayRx PO Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

# Authorization for Release of Information for Uniform Medical Plan (PEBB and SEBB) Members

**Section 1: Information about the use or disclosure**

I authorize the use or disclosure of personal health information about me as described below. I understand that this authorization is voluntary, and I may revoke it at any time as described in Section 2.

## Member Information

**Name** _____

I am currently enrolled in the Uniform Medical Plan (UMP) or was enrolled at the time of these services (**please check one of the following**):

- ☐ UMP Public Employees Benefits Board (PEBB) – UMP Rx Group # 10008217
- ☐ UMP School Employees Benefits Board (SEBB) - UMP Rx Group # 10016720

**UMP I.D. number: W**_____ **Date of Birth** _____

## Authorization

☐ I authorize **ArrayRx** to provide the following personal health information about me: To the following individual(s):_____

Address, City, State and Zip Code**:**_____

The reason for disclosure/purpose of disclosure is: _____

This authorization will expire one year from the date of my signature or on_____, whichever comes first.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I check the box next to the type of information to be included with the disclosure:

- ☐ HIV/AIDS test or result information and related records
- ☐ Drug/alcohol diagnosis, treatment, or referral information
- ☐ Reproductive health
- ☐ Genetic testing information
- ☐ Mental health information
- ☐ Pharmacy related information

***(Please turn over)***

**Section 2: Important information about your rights**

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time prior to the expiration date or event noted above by telling my provider or UMP in writing. The cancellation will not affect any information either received or given to UMP before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, UMP may not release my information to any person or organization except those needed to determine my continued coverage, eligibility, and enrollment or as explained in the Notice of Privacy Practices.
- The person or organization that I authorize to receive information about me or my dependent child(ren)* may share it with another person or organization. The information may end up with a person or organization that is not required to protect it the same way UMP is.
- UMP's Notice of Privacy Practice is available *by visiting HCA's website at* ***hca.wa.gov/ump-privacy.***
- This authorization will expire one year from the date below, unless otherwise noted above in the authorization section.

**Section 3: Signature**

_____ _____

Signature of member or member's representative — Date

***Form must be completed before signing.***

_____ _____

Printed name of member's representative — Relationship to member

Please attach legal documentation if you are the guardian, custodian, holder of power of attorney or another representative of the member.

**Please submit the requested information to:**
**ArrayRx**
**Attn: Privacy Office**
**PO Box 40168**
**Portland, OR 97240-0168**
**Or fax to: (503) 412-4068 (a secure fax line) at your earliest convenience**
**For any questions call us at 1-888-361-1611 (TRS: 711)**
**Monday-Friday, 7:30 a.m. to 5:30 p.m**