



Protected health information disclosure authorization

When completed, this form signifies member authorization allowing the disclosure of protected health information to another person/entity. To expedite your authorization, please print legibly in black or blue ink and return as instructed.

Member (Patient) Information

Name	Date of birth (mm/dd/yyyy)	ID no.
Employer name	Group no.	

Authorization

I understand that in connection with the provision of member services to me, Ardon Health has certain protected health information pertaining to me. I authorize Ardon Health to use and disclose a copy of my protected health information to:

Name	Relationship			
Address	City	State	ZIP	

For the purpose of (select one):

Discussing all information related to my insurance coverage, treatment and payment.

Other (please specify purpose): _____

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

Additional laws relating to use and disclosure of the information apply if the information disclosed contains any of the types of records or information listed below.

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

I understand that I have the right to refuse to sign this authorization. My refusal to sign this authorization will not affect my enrollment in a health plan or eligibility for health benefits.

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 used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back.

To revoke this authorization, please send a written statement to: Ardon Health, Privacy Office at 601 S.W. Second Ave., Portland, OR 97204 and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this authorization shall be in force and effect until the following (select one):

Date: _____ / _____ / _____ (not to exceed 24 months from the date of signature)*

Event: _____
(The event will be limited to 24 months maximum. Listing an event such as "Death," "Termination of Policy" or "Until Revoked" are examples of invalid events which will result in the return of this authorization as invalid).

By signing below, I agree that I have reviewed and I understand this authorization

Signature of individual X	Signature date
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or

Signature of individual's representative X	Signature date
Print name of representative	Relationship**

**If a date is not submitted (left blank), the authorization will be limited to 24 months from the date of signature.*

***Please attach legal documentation if you are the legal guardian, legal custodian or holder of Power of Attorney or have other legal authority for the member.*

All fields must be completed for this authorization to be valid. Member should retain a copy of the completed form.

Ready to submit?

Mail this form to Ardon Health, PO Box 20338, Portland Or 97294. Or, fax it to 855-425-4096.

Questions? Call 855-425-4085 or visit ardonhealth.com.

Washington State Rx Services does not discriminate

**Washington State Rx Services follows federal civil rights laws.
We do not discriminate based on race, color, national origin,
age, disability, gender identity, sex or sexual orientation.**

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

**If you need any of the above,
call Customer Service at:**

1-888-361-1611 (TDD/TTY 711)

**If you think we did not offer
these services or discriminated,
you can file a written complaint.
Please mail or fax it to:**

Washington State Rx Services
Attention: Appeal Unit
PO Box 40168
Portland, OR 97240-0168
Fax: 1-866-923-0412

**If you need help filing a complaint,
please call Customer Service.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

**Dave Nessler-Cass coordinates
our nondiscrimination work:**

Dave Nessler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com



ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجاناً. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzen zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با تماس بگیرید. (TTY: 711) 1-877-605-3229

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ: បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.