



Authorization to Disclose Personal Health Information

Section 1

Member name (print first and last name):

Lipa member ID number:

Date of birth (mm/dd/yyyy):

Check this box if you are a member of both Lipa and Trillium Community Health Plan (Trillium). (If you are a member of both Lipa and Trillium, this authorization will apply to both plans.)

Section 2

In the boxes below, choose the personal health information you want disclosed. If you want ALL requested information disclosed, mark the ANY information box. If you only want certain information disclosed, you must tell what information you want disclosed.

Disclose ANY information

Disclose only the following limited information:

Plan eligibility Claims information

Plan enrollment Premium payments

Disclose only the information listed below (write in the information you want disclosed).

Section 3

Check only one box below telling how long Lipa can use this authorization to disclose your personal health information.

Disclose my personal health information indefinitely

Disclose my personal health information for a specified period only, starting:
(mm/dd/yyyy): _____ and ending: (mm/dd/yyyy) _____

Section 4

Fill in the name and address of the person(s) or organization(s) to whom you want Lipa to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

Name:

Address:

Name:

Address:

Name:

Address:

Section 5

I authorize Lipa to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

Signature:

Telephone number:

Date (mm/dd/yyyy):

Print the address of the person who is the Lipa member (Street address, City, State, and ZIP):

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Lipa signed above.

Print the Personal Representative's address (Street address, City, State, and ZIP)

Print the Personal Representative's telephone number (including area code)

Print the Personal Representative's relationship to the beneficiary



Section 6

Return the completed, signed authorization by mail or fax to:

Lipa
PO Box 11740
Eugene, Oregon 97440-1740

Lipa Fax: 541-485-0737

Section 7

Note: You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Lipa has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Lipa pays for the health services you receive.

If you need help completing this form, please call our Member Services Department at (541) 485-2155. TTY users should call toll-free (877) 600-5473.

Lipa Member Services has the following hours to serve you: 8 am to 5 pm, Monday through Friday.

To receive this material in an alternate format or language call: (541) 485-2155.