HIPAA Authorization Form

Authorization for the Release of Protected Health Information

This form is used to confirm permission for ATRIO Health Plans and related entities to discuss or disclose your personal information, including your Protected Health Information, to a particular person (or persons) who acts as your Authorized Representative.

This document is available in alternate formats or for persons with special needs. Please call 1-877-672-8620 (TTY 711) to request this service.

Please complete all sections of this HIPAA Authorization Form and sign it in the last section. If any sections are left blank, this form will be invalid. Use "N/A" if not applicable.

Send the completed form back to ATRIO:

Fax: (541) 672-8670, or

Mail: ATRIO Health Plans, 550 Hawthorne Avenue SE, Suite 140, Salem, OR 97301

Section 1 – Patient/Plan Member Information	
Last Name: _____	
First Name: _____	Middle Name: _____
Member ID: _____	Date of Birth: _____
Address: _____	
City/State/ZIP: _____	

Section 2 – ATRIO Health Plans Authorized to Disclose PHI
Name: **ATRIO Health Plans**
Address: **550 Hawthorne Avenue SE, Suite 140**
City/State/ZIP: **Salem, OR 97301**

Section 3 – Individual/Organization Authorized by Signer to Receive PHI

Name: _____

Relationship to Patient/Plan Member: _____

Telephone #: _____

Address: _____

City/State/ZIP: _____

If you would like to authorize more than one person, please add their information below.

Name: _____

Relationship to Patient/Plan Member: _____

Telephone #: _____

Address: _____

City/State/ZIP: _____

Name: _____

Relationship to Patient/Plan Member: _____

Telephone #: _____

Address: _____

City/State/ZIP: _____

Section 4 – Authorization Expiration Event or Date

Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. **Note:** If no date or event specified below, then this authorization will expire one year from the signature date.

Expiration Event: _____ Expiration Date: _____

Section 5 – Health Information to be Disclosed - General

I authorize the following Protected Health Information to be disclosed:

☐ Medical Records ☐ Dental Records ☐ Other

If "Other," provide details: _____

Section 6 – Health Information to be Disclosed – Specific

I authorize the following Protected Health Information to be disclosed:

☐ Communicable Disease Signature: _____ Date: _____

☐ Reproductive Health Signature: _____ Date: _____

☐ HIV Test Results Signature: _____ Date: _____

☐ Mental Health Records* Signature: _____ Date: _____

☐ Substance Use Disorder Signature: _____ Date: _____

☐ Other Signature: _____ Date: _____

If "Other," provide details: _____

***Requests for psychotherapy notes require a separate HIPAA Authorization Form and may not be combined with any other request.**

☐ Psychotherapy Notes Signature: _____ Date: _____

Section 7 – Purpose of the Release or Use of Health Information

☐ Healthcare ☐ Research ☐ Legal

☐ Other (please specify): _____

Note: ATRIO Health Plans will not use or share your PHI unless we are allowed or required by law to do so.

Section 8 – Authorization Information

I understand the following:

1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4.

2. I have the right to revoke this authorization at any time. To revoke it, I must submit my revocation in writing ATRIO Health Plans at the address listed in Section 2. My revocation will stop ATRIO Health plans from making any further disclosure of my health information as of the date of receipt. If my health information is held or disclosed by another entity acting on ATRIO's behalf, there may be a short delay before my revocation takes effect as to that entity. My revocation will not apply to any action ATRIO already took in reliance on this authorization before receiving my revocation.

3. I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.

4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations.

5. I have a right to receive a copy of this HIPAA Authorization Form.

6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

By adding your initials and today's date below, you acknowledge that you understand the points noted in this section.

Member's initials _____ Today's date: _____

Section 9 – Additional Conditions that Apply to this HIPAA Authorization Form
(If no additional conditions or instructions needed, please put "N/A" below.)

Section 10 – Signature by or on Behalf of Patient/Plan Member
Name of Patient/Plan Member (Print) _____
Signature: _____ Date: _____
Name of signer if not Patient/Plan member: _____
Authority to sign on behalf of Patient/Plan Member: _____
Name of Translator (if applicable): _____
Signature of Translator (if applicable)_____