

Health Care Information And Records Release Form

Member/Enrollee Name: _____ Date of Birth: _____
(First/MI/Last)

Subscriber Name: _____ Subscriber ID Number: _____
(First/MI/Last)

HEALTH CARE INFORMATION AND RECORDS TO BE RELEASED TO:

Name: _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

City: _____ State: _____ Zip: _____

TYPES OF INFORMATION TO BE RELEASED: I permit _____, to release the following health care information to the person listed above. I understand that FamilyCare, Inc. needs my written consent to release any health care information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS) or psychiatric disorders/mental illness. Based on the box(es) I have checked below, FamilyCare, Inc. may release all diagnostic, procedural, claim or other related information and records.

- | | |
|---|---|
| <input type="checkbox"/> General Health Care | <input type="checkbox"/> Sexually Transmitted Diseases (HIV/AIDS) |
| <input type="checkbox"/> Alcohol and/or Chemical Dependency | <input type="checkbox"/> Psychiatric Disorders/Mental Illness |
| <input type="checkbox"/> Reproductive Health (including Abortion) | <input type="checkbox"/> Other: _____ |

PURPOSE FOR RELEASE AND HOW INFORMATION WILL BE USED:

- At the request of the Individual
 Authorization necessary for determination of enrollment or eligibility for benefits (see Section XX below)
 Research purposes
 Other: _____

TIMEFRAME OF RELEASE: Unless I revoke it, this release will remain valid for ninety (90) days from the date of my signature below or at the end of the research event if checked above.

Signature: _____ Date: _____

Print Name: _____

*If not the member/enrollee, I am the Parent Legal Guardian Holder of Power of Attorney
If you are the legal guardian or holder of a power of attorney for the member/enrollee, attach legal documentation.

REVOCAION OF RELEASE: I understand that I may change my mind and revoke this release at any time. I will do this by letting FamilyCare, Inc. know of my decision. Any change will be effective when FamilyCare, Inc. receives my written notice at 2121 SW Broadway, Suite 300, Portland, Oregon 97201. I understand that some or all of this information may already have been shared and that FamilyCare, Inc. will not be liable for any information already released.

REDISCLASURE: Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules. Should I have any concerns this has occurred, I may contact the FamilyCare, Inc. Privacy Officer at (8003) 335-3205.

Please keep a copy of this release for your records.