



LifeWise Health Plan of Oregon

# Non-Disclosure Request

Once you completely fill out this form and return to LifeWise Health Plan of Oregon (LifeWise) we will not share your personal protected information (PPI) with the person you name.

## 1 Member's Information:

First Name:			Last Name:			Date of Birth: MM/DD/YY [ ] [ ] / [ ] [ ] / [ ] [ ]			
ID Prefix: (see ID card) [ ] [ ] [ ]		ID #: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] - [ ] [ ]			Suffix: [ ] [ ]		Group/Policy #: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]		
Address:				City/State:			Phone Number:		

## 2 Who should we **not** share your information with?

First Name:		Last Name:	
Relationship to member:		Phone Number:	

## 3 What information should we not disclose:

What types of information should we **not** share with the person in Section 2? **Check all that apply:**

- General Health Information
- Alcohol and/or Chemical Dependency
- Sexually Transmitted Diseases (HIV/AIDS)
- Genetic Information
- Reproductive Health (including abortion)
- Gender affirming care, gender dysphoria, domestic violence, and behavioral health

Must check at least one

*To respond to your request we may not be able to share other types of PPI as well.*

## 4 Alternate Address: Where should we send your written information? Please check one box below:

- Address written in Section 1. (If checked, proceed to Section 5.)
- Alternate address, please write address below:

Address:	City:	State:	Zip Code:
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## 5 Sign and Send:

You must still pay for all costs related to your health plan. These include deductibles, copayments, coinsurance, and any non-covered charges owed to providers. This request applies only to your current health plan. It stays in effect unless you notify us in writing. We may have already shared your PPI with the person named in Section 2 before we received this request or while we were acting on it. We are not liable for these disclosures. We will deny or stop acting on a request that includes any minor children, if that request does not agree with court orders or documents. This release is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this release. We will act upon your request within 3 business days of the mail receipt date. Due to automated standard HIPAA transactions, Premera won't be able to enforce this in all cases for health care providers.

Signature (print to sign): <b>X</b>	Date of Signature:
Printed Name:	

## 6 If not the member, Legal Guardian Parent Holder of Power of Attorney/Legal Representative I am the: (must attach supporting legal documentation)

**Mail to:** Member Appeals PO Box 91102 Seattle, WA 98111 • **Fax:** 425-918-5592



### Discrimination is Against the Law

LifeWise Health Plan of Oregon (LifeWise) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@LifeWiseHealth.com](mailto:AppealsDepartmentInquiries@LifeWiseHealth.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### Language Assistance

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-596-3440 (TTY: 711).

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-596-3440 (TTY: 711).

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-596-3440 (TTY: 711)。

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-596-3440 (телетайп: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-596-3440 (TTY: 711) 번으로 전화해 주십시오.

**УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-596-3440 (телетайп: 711).

**注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-596-3440 (TTY:711) まで、お電話にてご連絡ください。

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-596-3440 (رقم هاتف الصم والبكم: 711).

**ATENȚIE:** Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-596-3440 (TTY: 711).

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-596-3440 (TTY: 711)។

**XIYYEEFFANNA:** Afaan dubbattu Oroomiiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-596-3440 (TTY: 711).

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.  
Rufnummer: 800-596-3440 (TTY: 711).

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-596-3440 (TTY: 711) تماس بگیرید.

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-596-3440 (ATS : 711).

**เรียน:** ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-596-3440 (TTY: 711).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.  
Tumawag sa 800-596-3440 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-596-3440 (TTY: 711).

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-596-3440 (TTY: 711).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-596-3440 (TTY: 711).

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-596-3440 (TTY: 711).