LifeWise

Authorization for Collection, Use and Disclosure (Sharing) of Personal Information

For Underwriting and Enrollment

Please fill out the information below. Print clearly. Make a copy for your records and mail the completed form to the address below.

MEMBER/ENROLLEE NAME: _____ **DATE OF BIRTH:** ___/___/___
(First name/Middle initial/Last name) (MM/DD/YY)

SUBSCRIBER NAME: _____ **MEMBER CASE NUMBER:** _____

YOUR INFORMATION (IF NOT THE MEMBER):
YOUR NAME: _____
(First name / Middle initial / Last name

Your relationship to the member/enrollee: ☐Parent ☐Legal guardian ☐Holder of power of attorney

Important: If you are not enrolling yourself, you must be the parent, legal guardian or holder of power of attorney of the person you are enrolling. If you are the legal guardian or holder of power of attorney, please send legal proof with this form.

HEALTH CARE INFORMATION AND RECORDS TO BE RELEASED BY:
NAME: _____

HEALTH CARE INFORMATION AND RECORDS TO BE RELEASED TO:

LifeWise Health Plan of Oregon
P.O. Box 91120, Seattle, WA 98111-9220
Fax: 1-800-291-4145
Phone: 1-800-592-6804

By signing below, I understand and agree to the following:

TYPE OF INFORMATION TO BE RELEASED: With the exception of genetic information, I allow any healthcare provider, hospital, insurance or reinsurance company, or the Medical Information Bureau, Inc., to share my personal health information with LifeWise Health Plan of Oregon (LifeWise) or its agent. This information may include:

- any and all diagnostic, procedural, treatment, claim, drug or other health-related information
- records concerning alcohol and/or chemical dependency
- records concerning reproductive health (including abortion), sexually transmitted diseases, HIV and AIDS
- records concerning psychiatric disorders and mental illness.

PURPOSE OF DISCLOSURE: LifeWise will use my personal health information to make decisions about my eligibility to enroll in the health plan.

CANCELLING THIS AUTHORIZATION: I may change my mind and cancel this release at any time by writing to LifeWise. After LifeWise gets my written notice, LifeWise will cancel this release within five (5) business days. During these five days, LifeWise may have already used some or all of this information to make decisions that will not be changed by my cancelling this authorization.

SIGNATURE REQUIREMENT: I must fill out this form to be considered to join a LifeWise health plan or be eligible for benefits. If I do not sign this authorization, LifeWise may not enroll me in a health plan or give me benefits.

SHARING MY INFORMATION: LifeWise may have to redisclose my personal health information to another party. State and federal privacy rules may not protect this information after LifeWise releases it.

DURATION OF RELEASE: This release lasts for twenty-four (24) months from the date of my signature below.

By using this document, I agree to the following: This document is for reference only. I may not change this document in any way. The current version of this document takes the place of older versions.

Sign your name: _____ Date: _____

Print your name: _____

If you have any questions about this form, please call Customer Service at 1-800-592-6804.

LifeWise

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. 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-596-3440 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, 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).