

## Authorization to Disclose Protected Health Information

### **Notice to Member:**

- Completing this form will allow **Trillium Community Health Plan** to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with **Trillium Community Health Plan** will not change if you do not sign this form.
- Right to cancel (revoke): When you want to cancel this Authorization Form, fill out the Revocation Form and mail it to us at the address at the bottom of the page.
- **Trillium Community Health Plan** cannot promise that the person or group you want to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. **Trillium Community Health Plan** can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the page.

### **Member Information:**

Member Name (print): \_\_\_\_\_

Member Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member [Medicaid/Medicare] ID Number: \_\_\_\_\_

**I give Trillium Community Health Plan permission to share my health information with the person or group (recipient) named below. The purpose of the authorization is to help me with Trillium Community Health Plan benefits and services.**

### **Recipient Information:**

Name (person or group): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **Trillium Community Health Plan can share this Health Information: (check all boxes that apply)**

- ☐ All of my PHI;                      **OR**                      ☐ All of my PHI **EXCEPT:**
- ☐ Alcohol/drug diagnoses, treatment, or referral
  - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information.
  - ☐ Behavior health services or psychiatric care information (except psychotherapy notes)
  - ☐ Genetic testing information
  - ☐ Other \_\_\_\_\_

**Authorization End Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (date the authorization ends unless cancelled)

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or court order of guardianship).

**Mail To: Trillium Community Health Plan**  
Attn: Compliance Department, PO Box 11740, Eugene, OR, 97440  
Compliance Toll Free Fax: (1-844) 426-5340

**Do you think Trillium Community Health Plan (TCHP) has treated you unfairly?**

Trillium must follow state and federal civil rights laws. It cannot treat people unfairly in any of its programs or activities because of a person's:

- Age
- Gender identity
- Race
- Sexual orientation
- Color
- Marital status
- Religion
- Disability
- National Origin
- Sex

Everyone has a right to enter, exit and use buildings and services. They also have the right to get information in a way they understand. Trillium will make reasonable changes to policies, practices, and procedures by talking with you about your needs.

To report concerns or to get more information, please contact Member Services at 541-485-2155; Toll Free: 1-877-600-5472; TTY: 1-877-600-5473, Monday through Friday, 8:00 a.m. to 5:00 p.m. At other times – including Saturday, Sunday, and federal holidays – you can leave a voicemail. We will return your call the following business day. The call is free.

You also have a right to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights. Contact that office one of these ways:

- Web: [www.hhs.gov](http://www.hhs.gov)
- Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)
- Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
- Mail: 200 Independence Ave., SW, Room 509F HHH Bldg.  
Washington, D.C. 20201

**English**

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-600-5472; TTY: 1-877-600-5473.

**Español (Spanish)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**繁體中文 (Chinese)**

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Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**Русский (Russian)**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**한국어 (Korean)**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**Українська (Ukrainian)**

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером. Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**日本語 (Japanese)**

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。Medicaid 1-877-600-5472; TTY: 1-877-600-5473. まで、電話にてご連絡ください

**Arabic:**

تنبيه: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بـ Medicaid على رقم 1-877-600-5472، رقم هاتف الصم والبكم: 1-877-600-5473.

**Română (Romanian)**

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**ខ្មែរ (Cambodian)**

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**Cushite**

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**Deutsch (German)**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**(israF) فارسی**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرد. فراهم می باشد. با. Medicaid 1-877-600-5472; TTY: 1-877-600-5473.

**Français (French)**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Medicaid 1-877-600-5472; TTY: 1-877-600-5473

**ภาษาไทย (Thai)**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร. Medicaid 1-877-600-5472; TTY: 1-877-600-5473.