Essential Worker Healthcare Trust

Person-centered healthcare coverage for long-term care workers designed with the help of long-term care workers.

Phone 833-389-0027
Web EssentialWorkerHealth.org
Email EssentialWorker@RISEpartnership.com

Consent to Release Information

Respecting your privacy is vital to us, and we take our responsibility to protect the privacy and confidentiality of your information very seriously. By the Essential Worker Healthcare Trust's policies and by law, we cannot release your personal information, including your personal health information, to anyone other than you except where it is allowed by law. However, we understand that sometimes it is more convenient for you to have a trusted family member or friend ask questions, or confirm information on your behalf. **This Consent to Release Information is optional** and designed for you to let us know who you trust with your confidential information.

THIS FORM IS OPTIONAL

I, _____ , give the Oregon Essential Workforce Health Care Fund ("Fund" or "EWHT") permission to disclose my health information with the person or organization listed below.

1. **Who Can Access My Information:** Write the name(s) or group of people you want to allow access to your health information (for example: "Jane Doe" or "all doctors"):

2. **What Information Can Be Shared:** Write down the type of health information that can be shared (for example: "Any claims or benefit details"):

3. **Why I Am Allowing Information to Be Shared:** Write why you're giving this permission, or just write "at my request."

4. **When Does This Permission End.** This authorization will expire: [choose and complete one]:
   - ☐ When my coverage ends
   - ☐ On this specific date:
   - ☐ When this happens (for example, "when my claim is resolved"):

Phone 833-389-0027
Web Essentialworkerhealth.org
Email EssentialWorker@RISEpartnership.com

5. **Cancellation of This Consent:** I understand that I have the right to cancel this permission at any time. To do so, write to us at: EssentialWorker@RISEpartnership.com or EWHT at PO Box 94392, Seattle, WA 98124. I understand that cancelling will not undo anything already shared before EWHT received the request.
6. **Potential for Your Information to Be Reshared:** I understand that after the information described in (2) above is shared with others, it might not be protected by federal law and the person or group who receives the information could share it again.
7. **You May Request a Copy:** I understand that I can ask for a copy of this form.
8. **Signing This Form Is Voluntary:** I understand that signing this form is my choice and acknowledge that I am voluntarily signing this form to release my health information to the person I have chosen.
9. **Your Benefits Will Not Be Changed:** I understand that I am not required to sign this form to receive my benefits, nor does signing this form alter my enrollment in the Essential Worker Healthcare Trust benefits, my eligibility, or any payments I may owe under EWHT.

☐ By checking this box, I have reviewed and understand the contents of this form and agree that it accurately reflects my wishes.

_____ _____

Date

Individual's Signature
If you're filling out this form online, just type your name.

Personal Representative Section

If a Personal Representative completes the form for you (like a legal guardian or someone with power of attorney), they must show proof of their authority to sign. Examples include:

- A notarized power of attorney for healthcare (attach a copy).
- A court order naming them as your guardian or conservator (attach a copy).
- Proof they are a parent of a minor child.
- Other:

NOTE: This consent will not be effective unless you provide all the information requested.