

Permission to Contact Another Person on My Behalf

Office use	_____	Date Stamp code
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FAX request to: 503-373-7866 or 503-378-4139

If you think we may not be able to find you when your name is drawn, or if there is another person you would like to know about your status in the Oregon Health Plan drawing for adults, you can choose a back-up contact. When your name is drawn we will send a letter to you and we will send a letter to your back-up contact.

1. My information

Print your full name: _____

Date of birth: ____ / ____ / ____

Address: _____

City, State, ZIP: _____

Phone: _____ E-mail: _____

2. Back-up contact information

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ E-mail: _____

I understand that the person I choose may not agree to act as my back-up contact.

When I sign below I give permission to the Oregon Health Authority/Department of Human Services to share two things with my back-up contact: (1) my name and (2) my status in the Oregon Health Plan drawing for adults. This information is being given to my back-up contact to keep them informed of my status in the Oregon Health Plan drawing for adults. Oregon Health Authority/Department of Human Services may not share or use this information for any other purpose.

3. Your signature is required

Signature: _____ Date: _____