Member Authorization

TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Harvard Pilgrim Health Care

Note: **Incomplete forms cannot be processed and may be returned to you for completion.**
Please call **(888) 609-0692** or TTY# **711** if you need assistance or have questions.

The following elements are required in order for Harvard Pilgrim to process your request.

Member Information			
Member Name			
Member HP ID # (not required for new enrollees without ID#)		**Home Address**	
Date of Birth		**Phone #**	

Information Authorized to be Released/Disclosed: I hereby authorize Harvard Pilgrim to release/disclose the health information described below to the "Recipient" identified below for the specified purpose.	
Health information to release/disclose (be specific, including types of information and dates)	
Name of Recipient (person or entity authorized to request and receive health information)	
Role of Recipient	
Address of Recipient	
Purpose (provide a specific purpose)	

Protected Categories: If your information includes any of the following types of protected categories, Harvard Pilgrim will NOT disclose such information UNLESS you specifically authorize us to release/disclose the information to Recipient by providing your initials next to the protected category.

Abortion		**Behavioral Health**		**HIV**	
AIDS/ARC		**Genetic Testing**		**Physical Abuse**	
Alcohol & Substance Abuse		**Domestic Violence**		**Reproductive Health**	
Sexually Transmitted Infection					

TERMS OF THIS AUTHORIZATION

1. I understand that Harvard Pilgrim will not condition my treatment, enrollment, or eligibility for health insurance benefits on my signing of this Authorization.
2. I understand that Harvard Pilgrim will release my health information as directed by the terms and conditions of this Authorization. I understand that information once released according to this Authorization is out of Harvard Pilgrim's control and Harvard Pilgrim becomes unable to further safeguard such information or prevent redisclosure by the Recipient.
3. I understand that I have a right to receive a copy of this Authorization.
4. I understand that I may revoke this Authorization in writing at any time.
5. I desire this Authorization to remain in effect until _____ *(please specify a date)*. I understand that if I do not specify a date, this Authorization will remain in effect for two (2) years from the date of signature on this form. (For a minor, this Authorization will expire in two (2) years or the day before the minor's 18th birthday, whichever is earlier.)

I have read and understand the terms of this Authorization and I hereby authorize the release/disclosure of my health information in the manner described above.

_____	_____	_____
Signature* (required)	**Date** (required)	**Printed Name*** (required)

This Authorization will only be valid if it is signed by the member or other person with legal authority for the member. If you are not the member, please indicate your relationship to the member below.

☐ **Legally authorized representative** (e.g., power of attorney)

Form of legal authorization**: _____

***You must submit a copy of the legal authorization if not already provided.*

SEND COMPLETED FORM TO:

Harvard Pilgrim Health Care
PO Box 690545, Quincy, MA 02269
Fax: (617) 509-4222

This **Member Authorization** form is used for a member to authorize Harvard Pilgrim to disclose information to an individual or entity.

Note: The Member Authorization form is not necessary for parents of minor children currently enrolled on the same policy to receive information about the minor, unless the information is related to a protected category (see additional restrictions below).

Please read the following instructions prior to completing this form.

Information Authorized to be Released/Disclosed: Please complete this section to identify the information that should be disclosed and the recipient authorized to receive it.

> **Health information to release/disclose:** You may limit the information by type (for example, demographic information or claims information) or by a certain time period.
>
> **Name of Recipient**: You may authorize either an individual or entity/company to receive your information. The individual/entity must be specifically named.
>
> **Role of Recipient:** For example, parent/guardian, broker, consultant.
>
> **Address of Recipient:** Address of the individual/entity authorized to receive your information.
>
> **Purpose:** The authorization for release of information must be related to a specific issue or event (for example, to solve a claim or benefit issue).

Protected Categories: For individuals age 12 and older, information related to the protected categories will not be disclosed unless specifically authorized by the member. The member may choose to authorize the disclosure of information in none, some, or all of the listed categories.

Who should sign the form?

This form must be signed by the member or a person with legal authority for the member (for example, power of attorney or health care proxy). If signed by someone other than the member, a copy of the legal authorization must also be submitted if not already on file.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-609-0692 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-609-0692 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-609-0692 (TTY: 711).

繁體中文 (Traditional 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 1-888-609-0692（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-609-0692 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-609-0692 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم ألُلغةِ **ألعربية** ، خَدَمات ألمُساعَدة ألُلُغَوية مُتَوفرة لك مَجاناً. **إتصل على 1 -888-609-0692**

(TTY: 711 **)**

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-609-0692 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-609-0692 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-609-0692 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-609-0692 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-609-0692 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-609-0692 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-609-0692 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-609-0692 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-609-0692 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-609-0692 (TTY: 711).

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- 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, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC 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 Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer 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 Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.