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.