Member Authorization

TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Harvard Pilgrim Health Care

***Note:* Incomplete forms cannot be processed and may be returned for you to complete.**
Please call **(888) 333-4742** or TTY# **711** if you need assistance or have questions.

Member HP ID #			
Member Name			
Home Address			
Phone #		Date of Birth	

INFORMATION AUTHORIZED TO BE RELEASED/DISCLOSED – *I hereby authorize Harvard Pilgrim to release/disclose the health information described here to the "Recipient" identified below for the purpose stated.*

Health information to release/disclose to Recipient (be specific, including types of information and dates)	
Name of Recipient (person authorized to request and receive health information)	
Role of Recipient	
Address of Recipient	
Purpose (please provide a specific purpose or you may state "at my request")	

PROTECTED CATEGORIES – *If your information includes any of the following types of protected categories, Harvard Pilgrim will NOT disclose such information UNLESS you provide your initials next to the protected category, to indicate YES that you authorize us to release/disclose the information to Recipient.*

Abortion		Behavioral Health		HIV		Communicable Diseases (venereal disease)	
AIDS/ARC		Genetic Testing		Physical Abuse			
Alcohol & Substance Abuse		Domestic Violence		Reproductive Health			

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 from re-disclosure 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 signature date on this form.

   For a minor, this Authorization will expire the day before the minor's 18th birthday.

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*	**Date**	**Printed Name***

**This Authorization will only be valid if it is signed by the member, a person with legal authority for a member, or the parent or legal guardian of a member that is a minor. If you are not the member, please indicate your relationship to the member:*

❑ **Parent or legal guardian of the minor member** **Relationship to minor** _____

❑ **Legally authorized person** **Form of legal authorization** *(e.g., power of attorney)* _____

SEND COMPLETED FORM TO:

Harvard Pilgrim Health Care, ATTN: Customer Service
1600 Crown Colony Drive, Quincy, MA 02169
Fax: (617) 509-1050