Designation of Representative Statement

Harvard Pilgrim Health Care

Please call **(888) 333-4742** or TTY# **711** if you need assistance or have questions.

MEMBER INFORMATION			
Member Name			
Date of Birth		Harvard Pilgrim ID #	
Phone #		Home Address	

DESIGNATED REPRESENTATIVE INFORMATION			
Name of Designated Representative			
Date of Birth		Relationship to Member	
Phone #		Home Address	

I affirm that I am the above named Member of Harvard Pilgrim Health Care. I do hereby appoint the above named individual as my Designated Representative in making decisions related to my health care, coverage and all levels of appeal and receiving and disclosing my protected health information (PHI). **I hereby authorize Harvard Pilgrim to disclose my PHI to my Designated Representative.**

Member's signature _____ **Date** _____

I hereby agree to serve as the above mentioned Harvard Pilgrim Health Care's Member's Designated Representative acting on his/her behalf in making decisions related to health care and coverage and all levels of appeal including use and disclosure of his/her protected health information.

Designated Representative's signature _____ **Date** _____

PROTECTED CATEGORIES – *If your Harvard Pilgrim files contain the following types of information, you must opt in by choosing 'Yes' next to each category if you want us to share the information with your Designated Representative, or choose 'No' to opt out. If you do not answer, we will default to 'No' and not share this information.*

	Yes	No		Yes	No		Yes	No
Abortion			Behavioral Health			HIV		
AIDS/ARC			Genetic Testing			Physical Abuse		
Alcohol & Substance Abuse			Domestic Violence			Reproductive Health		
						Communicable Diseases (venereal disease)		

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 understand that this Authorization will remain in effect until _____ **(enter date or event here)** or until I revoke this Authorization in writing or within 1 year from the date that I sign this Authorization, which ever should occur first. (If you are a minor or if this form is being signed on behalf of a minor, the form will expire the day before the minor's 18th birthday.)

PLEASE SEND COMPLETED FORM TO:

Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169

Fax: (617) 509-1050