Clear Form

Authorization to Obtain Protected Health Information

This form may be used to authorize Health Plans, Inc. (HPI), as a claims administrator of my Employee Health Benefit Plan, to obtain my Protected Health Information from the person(s) indicated on this form.

All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.

MEMBER'S INFORMATION: For the individual requesting disclosure of their information (Member)			
Name:		**Member ID Number:**	
Street Address:			
City, State, ZIP Code:			
Date of Birth:		**Phone Number:**	
DISCLOSING ENTITY'S INFORMATION: Member hereby authorizes the following individual/entity (Entity) to disclose their information to HPI:			
Name:		**Relationship to Member:**	
Street Address:			
City, State, ZIP Code:			
Date of Birth:		**Phone Number:**	
Phone Number:			

INFORMATION TO BE DISCLOSED: Member hereby authorizes Entity to disclose the following information to HPI:

☐ **All** protected health information except protected categories *(see below)*

☐ Only eligibility, benefits, and demographic information

☐ Specific/Other records *(please describe, e.g., explanation of benefits, information relate to an appeal or grievance, etc.)*:

_____

Protected Categories: Entity will **NOT** disclose information related to any of the following categories unless specifically authorized to do so or otherwise required by law. Member must check off the box next to any of the following categories of information to be disclosed to the Recipient.

☐ Abortion ☐ Domestic Violence ☐ Physical Abuse

☐ AIDS/ARC ☐ Genetic Testing ☐ Reproductive Health

☐ Behavioral Health ☐ HIV ☐ Sexually Transmitted Infection

☐ Alcohol and substance abuse (including information about services provided by federally assisted substance use disorder treatment programs)

Terms of this Authorization

1. Entity is disclosing the information for the purpose of fulfilling the request of the Member.
2. Entity will not condition treatment, payment, enrollment, or eligibility for benefits on whether Member signs this Authorization.
3. Entity is disclosing the information in accordance with this Authorization. Once the information is disclosed according to this Authorization, it is no longer protected by HIPAA and may be redisclosed by HPI.
4. Member has a right to receive a copy of this Authorization.
5. Unless indicated here, this Authorization will remain in effect for two (2) years from the date of signature on this form (or, for a minor, the day before the minor's 18th birthday, whichever is earlier). If Member desires an alternate end date, please specify a date here: _____.
6. Member may revoke this Authorization in writing at any time prior to its termination, except to the extent that information has already been disclosed while this Authorization was in effect.

I have read and understand the terms of this Authorization and I hereby authorize the disclosure of my information in the manner described above. I represent that the signature below is my own and that I am legally authorized to sign this document.

Signature of Member or Personal Representative* **Date**

Printed Name **Relationship, if not Member***

*This Authorization will only be valid if signed by Member, the parent or guardian of Member if Member is a minor (unless Member is age 12-17 and the authorization includes information in protected categories), or Member's Personal Representative (e.g., power of attorney, health care proxy, etc.). If you are not Member, please indicate your relationship to Member above and submit a copy of the applicable legal documentation if you are a Personal Representative (if not already provided).

Please return this completed form and supporting legal documentation (if applicable) to:

HPI
Attention: Claims Department
P.O. Box 5199
Westborough, MA 01581
800-532-7575
hpiTPA.com