Member Authorization

TO RELEASE PROTECTED HEALTH INFORMATION

Harvard Pilgrim Health Care

Please call **1-888-333-4742** or **TTY#1-800-637-8257** if you need assistance or have questions.

Member HP ID #:		**Social Security #:(optional)**	__ __ __ - __ __ - __ __ __ __
Member Name			
Home Address			
Home Telephone		**Date of Birth**	

INFORMATION BEING REQUESTED

I hereby authorize Harvard Pilgrim to release ("disclose") the health information listed here to the "recipient" indicated below for the purpose indicated.

Health information to release (Be specific, including types of information and dates.)	
Name of Recipient	
Role of Recipient	
Address of Recipient	
Purpose ("at my request" is a sufficient answer)	

STATUTORILY PROTECTED INFORMATION

If your Harvard Pilgrim files have any of the following types of information, you must initial the space next to each category and provide your signature here or such information will not be released.

Abortion		**Alcohol & Substance Abuse**		**HIV Testing**		**Physical Abuse**	
AIDS/ARC		**Genetic Testing**		**Mental Health**		**Sexually Transmitted Diseases**	
Signature *							

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 upon request.
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 30 months from the date that I sign this Authorization, which ever should occur first.

I have read and understand the terms of this Authorization and I hereby authorize the release 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, the legal guardian of a member that is a minor, or by an individual that has a Harvard Pilgrim Designated Personal Representative form on file for this member. If you are not the member, please indicate your relationship to the member:

- ❑ **Legal guardian of the minor member. Relationship to minor:** _____
- ❑ **Designated Personal Representative.**

For Harvard Pilgrim Use Only (Date Stamp Required here)

- ❑ Copy of Authorization sent to Member. Date Sent: _____
- ❑ Check here if this is for an electronic feed and indicate where a hard copy can be located:_____