



MASS **ADVANTAGE**

P.O. Box 830059
Birmingham, AL 35283

Authorization to Release Protected Health Information (PHI) Form

Mail or fax this completed form and any relevant
documentation to Mass Advantage at 774-701-1416

Section 1 **Member Information**

Be sure to fill this section out completely. For example, if you live in an apartment, include apartment number. And be sure to include your Mass Advantage Member ID so we can easily find you in our system.

Section 2 **The Purpose of this Authorization**

Please tell us why you want us to release or share your information with this individual or entity.

Section 3 **Person or Entity that PHI Will Be Released to or Shared with**

Write the full name of the person or entity you want us to release your information to or share it with. Please be specific, don't use general words like "my daughter" or "my son". If you permit this person or entity to receive a mailed copy of your records, we will need their address.

If you would like us to share your information with more than one individual or entity, a separate form must be filled out for each one.

Section 4 **Type of Information that Mass Advantage is Authorized to Release or Share**

Complete this section if you would like to select the specific type of information that you want Mass Advantage to release to an authorized individual or entity.

Section 5 **Expiration and Revocation**

Provide an expiration (end) date or describe what will make this authorization expire. You can write "until the end of my care" or "until I am no longer a member of Mass Advantage" if you want to continue sharing your information with the person or persons you have chosen.

Section 6 **Important Information I Need to Know**

It is important that you read the information in this section before signing this form.

Section 7 **Member's or Authorized Party's Signature**

Signature of Adult Member or Authorized Party

If you are the adult member or the authorized part signing this form, please check the correct box to indicate your relationship to the member. Sign and print your name, and don't forget to include the date.



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Please Note: if you are the member signing this form, your name in this section must match the name used in Section 1.

If you are signing this form on behalf of the member, you must provide the supporting documentation authorizing you to represent the member.

Examples of Supporting Documentation (For Example, Legal Documentation)

- **Power of Attorney** – This legal document gives someone you trust permission to act on your behalf in healthcare billing/payment matters, which can include some health information. This individual cannot make healthcare decisions for you.
- **Executor of Estate** – This legal document is used when the member (you) is deceased and tasks an individual to handle the deceased member’s estate/affairs.
- **Healthcare Proxy** – This document gives someone you trust permission to make healthcare-related decisions if you are unable to make decisions or are incapacitated. **Note:** clinical documentation supporting the member’s (your) inability to make decisions must accompany the signed Healthcare Proxy form.
- **Guardianship** – This document gives a court-appointed individual authority to act on behalf of the member (you) and to take care of them, including their property, healthcare, etc.

By completing or signing this form, I, or my authorized party, permit Mass Advantage to share my PHI with the people or entities listed below. By Mass Advantage, I also mean the companies subsidiaries, affiliates, employees, agents, and subcontractors. For help in completing this form, call member Services phone number on your Mass Advantage Member ID card.



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Section 1 Member Information

First Name	Middle Name	Last Name
Member ID		DOB
Mailing Address (include Apt. #)		
City	State	Zip
Email	Phone Number	

Section 2 The Purpose of this Authorization

Please select the reason for this authorization request.

For My Use Other (please specify): _____

Section 3 Person or Entity that PHI Will Be Released to or Shared with

Please check the box to indicate the person's or entity's relationship to you:

Spouse Domestic Partner Adult Child Parent

Other (please specify): _____

Please complete the following information:

Individual or Entity Full Name

Mailing Address (include Apt. #)

City	State	Zip
Email	Phone Number	



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Section 4 Type of Information that Mass Advantage is Authorized to Release or Share

Method of Disclosure: Mail Email Phone

Date of Service: From _____ through _____

Type of Information to be Released

1. Standard Health Information:

Authorizations Health (medical, dental, pharmacy, vision and flexible spending account)

2. Sensitive information will not be released unless you specifically request it by checking the box and putting your initials in the space next to your selection:

Behavioral/Mental Health HIV/AIDS All Sensitive Information

Note: Psychotherapy notes will not be shared

SUBSTANCE USE DISORDER (SUD): In order to comply with the Federal Rules for Confidentiality of Alcohol and Drug Abuse patient Records (title 42 of the code of Federal Regulations, Chapter I, Part 2), the Authorization to Release Substance Use Disorder (SUD) Protected Health Information (PHI) form must be used to submit requests for SUD-related information.

Section 5 Expiration and Revocation

This authorization will automatically expire 24 (twenty-four) months from the date it is signed. Or, please insert a date or event that will make it expire before 24 months.

Authorization should expire on _____ (MM/DD/YYYY) or _____

Once the following event occurs: _____

Right to revoke: I may cancel this authorization form at any time. If I wish to do so, I can write to Mass Advantage’s Compliance/Privacy Office either by Mail Mass Advantage, P.O. Box 830059, Birmingham, AL 35283 or by fax at 774-701-1416. I understand it will not affect any action Mass Advantage took before they received my cancellation request.



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Section 6 Important Information I Need to Know

My signature below means that I understand and agree to the following: This authorization is voluntary and can be cancelled at any time. My cancellation will not affect any action Mass Advantage took before they received my cancellation request.

- With the exception of HIV/AIDS, my health information may be subject to re-disclosure by the recipient, and no longer protected by privacy regulations, if the organization or person authorized to receive the information is not a health plan or healthcare provider.
- Mass Advantage cannot condition my treatment, payment, enrollment, or my eligibility for benefits and payment for services if I do not sign this form. However, without a valid form, my request to release information to the individual(s) or entity(ies) named above cannot be fulfilled.

Section 7 Member's or Authorized Party's Signature

Signature of Adult Member or Authorized Party

If you are the adult member or the authorized part signing this form, please check the correct box to indicate your relationship to the member. Sign and print your name, and don't forget to include the date.

- Spouse Domestic Partner Friend Child
- Relative _____ Other _____

Please Note: if you are the member signing this form, your name in this section must match the name used in Section 1.

If you are signing this form on behalf of the member, you must provide the supporting documentation authorizing you to represent the member.

Signature

Date