Authorization to Release Protected Health Information (PHI) Form

MASS ADVANTAGE

Contact Information

Mail this completed form and any relevant documentation to Mass Advantage, P.O. Box 830059, Birmingham, AL 35283 or to fax 774-701-1416.

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.

First Name	Middle Initial	Last Name

Date of Birth (mm/dd/yyyy)	Mass Advantage ID#

Mailing Address (include Apt. #)

City	State	Zip

Phone Number	Email

2 The Purpose of this Authorization

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

Please select the reason for this authorization request.

☐ For My Use ☐ Other (please specify): _____

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.

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 Suite or Apt. #)

City | State | Zip

Phone Number | Email

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.

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.

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.

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.

6 Important Information I Need to Know

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

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.

7 Member's or Authorized Party's Signature

Signature of Adult Member or Authorized Party

If you are the adult member or the authorized party 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.

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.

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