TUFTS Health Plan

Authorization to Disclose Protected Health Information

Use this form to authorize Tufts Health Plan* to use or disclose your protected health information. All fields are required. Incomplete or incorrect forms will be returned.

Member Name: _____ **Member ID:** ☐☐☐☐☐☐☐☐☐☐☐☐

Member Address: _____, _____, _____
Street City and State Zip Code

Member Date of Birth: _____ **Member Phone number:** _____

I hereby authorize Tufts Health Plan to disclose the protected health information listed below to the following person/entity:

Name: _____ Address: _____

Relationship to Member: _____ _____

Protected health information to be disclosed (describe in a specific way the information to be disclosed):

Sensitive Information: If Tufts Health Plan has any of the following types of information about you, you must check off the box next to the category before we can disclose the information (information will not be disclosed unless the applicable box is checked):

☐ Information related to my diagnosis and/or treatment for HIV/AIDS

☐ Information related to my diagnosis and/or treatment for alcohol or drug abuse

☐ Results of genetic testing

Describe the purpose for the disclosure (be specific, e.g. "to assist with claims payment" or you may write "at my request"):

This authorization will remain in effect:

☐ From the date of this Authorization until the following date: _____

☐ For as long as necessary to complete the purposes of this Authorization.

☐ Until the following event occurs: _____

*For purposes of this Authorization, Tufts Health Plan refers to Tufts Associated Health Maintenance Organization, Inc., Tufts Associated Health Plans, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., and Tufts Insurance Company. It also refers to entities acting on behalf of Tufts Health Plan.

Please Note:

- You have a right to revoke this authorization in writing at any time and to send your written revocation to Tufts Health Plan at the address listed below. Your revocation will not apply to information that Tufts Health Plan has already disclosed in reliance on this Authorization.
- Information disclosed by Tufts Health Plan in accordance with this request may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.
- Tufts Health Plan will not condition payment, enrollment in the health plan, or eligibility for benefits on you providing this authorization.

Signature:

I have read and understand the above information. I represent that the signature below is my own and that I am legally authorized to sign this document.

_____	_____	_____
Member, Parent, or Personal Representative's* Signature	**Print Name**	**Date**

Relationship, if signed by other than Member: _____

**If not already provided, please attach legal documentation verifying personal representation. We will require verification of the authority of a Personal Representative before this request will be considered complete.

Please Return This Completed Form and Supporting Documentation To:

Tufts Health Plan • Member Services, 705 Mt. Auburn Street• P.O. Box 9166 • Watertown, MA 02471-9166
Fax 617-972-9452

If you have any questions about this Authorization Form please contact a Tufts Health Plan Member Services Representative at:
1-800-462-0224 (TDD: 1-800-815-8580)