



AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name: _____
Member ID: _____
Date of Birth: _____
(MONTH/DAY/YEAR)

As described in our Privacy Notice, CeltiCare is required by law to obtain your authorization for any use or disclosure of your health records for purposes other than your treatment, the payment for health care services provided to you and health care operations of CeltiCare. In our Privacy Notice, we provided you information about how CeltiCare can use or disclose your health records. You have a right to review and receive a copy of our Privacy Notice before signing this Authorization.

I _____, authorize the use and disclosure of my health information as described below:

1. This authorization applies to the following information:

2. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

- ___ I specifically give permission, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.
___ I specifically give permission, to share information in my record about my genetic information.
___ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the re-disclosure of this confidential information.

3. I authorize the following persons (or class of persons) to receive my health information:

Name: _____
Title: _____
Address: _____
City/State/Zip: _____
Phone: _____

4. We are requesting this authorization in order to use or disclose your health information for the following purposes:

At the request of the member.

5. This authorization expires: _____
(Date or Event)

* If no date or event is given, permission will last for one year from the date this is signed.

You may request to inspect or copy the information that CeltiCare intends to disclose. You may refuse to sign this Authorization. CeltiCare will not condition treatment, payment, enrollment or eligibility for benefits on your providing or refusing to provide this Authorization. Once release of this health information is made to the above-named person or persons, your health information may be subject to redisclosure by that person or persons. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the end of this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this Authorization.

If you are requesting information for yourself or for a third party, CeltiCare may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

AUTHORIZATION

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to CeltiCare. I understand that, by signing this form, I am confirming my authorization that CeltiCare may use and/or disclose to the persons and/or organizations named in this form the health information described in this form.

Signature of Member or Legal Representative

Date

Print Name

If signing on behalf of a CeltiCare health plan member please describe your authority and provide related documentation:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

For CeltiCare Use Only

Name: _____ **Title:** _____

Signature _____

Please send completed form to:
CeltiCare Health Plan of Massachusetts, Inc.
1380 Soldiers Field Road, Suite 300
Brighton, Massachusetts 02135

or
Fax No. 1-866-614-1953

This form is also available at www.celticarehealthplan.com