Dear Member,

Please complete this form in its entirety and mail it back, so that we have your permission to disclose your personal health information to the person you have chosen to be authorized as a contact on your behalf. Please note that within this form there is a section regarding personal health information that you may request to be undisclosed, even to your authorized contact. If any information on this form has not been completed in its entirety, with the exception of the health exclusions, we may send the authorization form back to you and ask you to complete it before we can disclose any of your personal health information to your authorized contact. This form becomes affective only when we have received it and deemed it to be complete.

Please mail this form to:

Attention: Member Services Department
1380 Soldiers Field Road
Brighton, MA 02135

Sincerely,
CeltiCare Member Services Department

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name: ______________________________

Member ID: ______________________________

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

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 ________________________

For the protection of you and your personal health information, please choose a security password/pass code up to five numbers or letters. This will be used to verify your authorized contact in order to disclose any of your personal health information, limiting the information you have requested on the form to be undisclosed. If your authorized contact is unable to verify the password/pass code, we must speak with you to verify your social security number, so that we may give you the password/pass code in case you cannot remember it. At this point, you may give the password/pass code to the authorized contact, and we may then disclose your personal health information to your authorized contact, limiting the information you have requested on the form to be undisclosed. Other important information that your authorized contact should be able to verify includes his/her address and your first and last name. Failure to be able to verify these pieces of information will result in nondisclosure of your personal health information to your authorized contact, without speaking to you first.

Password/Pass code ____________________

(Password/Pass code must be at least two letters/numbers but no less than five numbers/letters. Please be sure to distinguish the letter or number when printing, so that there is no confusion as to whether the character is a letter or a number. i.e. The letter L in its lower case form (l) could also look like the number 1.)

Member's Signature __________________________ Date ____________