Authorization to Disclose Protected Health Information

This form may be used to authorize CarePartners of Connecticut* to disclose a member's protected health information.
All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.

Member Information – For individual requesting disclosure of their information ("Member")	
Name:	**ID Number:**
Street Address:	
City, State, Zip Code:	
Date of Birth:	**Phone Number:**

Recipient Information – Member hereby authorizes CarePartners of Connecticut to disclose their information to the following individual/entity ("Recipient"):	
Name:	**Relationship to Member:**
Street Address:	
City, State, Zip Code:	
Date of Birth:	**Phone Number:**
Email Address:	

Information to be Disclosed – Member hereby authorizes CarePartners of Connecticut to disclose the following information to the Recipient:

☐ **All** protected health information except protected categories *(see below)*
☐ Specific records *(please describe, e.g., activity summary/explanation of benefits, etc.)*:

_____

☐ Only eligibility, benefits, and demographic information

Protected Categories: CarePartners of Connecticut will **NOT** disclose information related to any of the following categories unless specifically authorized to do so or unless otherwise required by law. Member must check off the box next to any of the following categories of information to be disclosed to the Recipient.

☐ Abortion
☐ AIDS/ARC
☐ Behavioral Health
☐ Domestic Violence
☐ Genetic Testing
☐ HIV
☐ Physical Abuse
☐ Reproductive Health
☐ Sexually Transmitted Infection
☐ Alcohol and substance abuse (including information about services provided by federally assisted substance use disorder treatment programs)

Terms of this Authorization

*For purposes of this Authorization, Tufts Health Plan includes Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Harvard Pilgrim Group Health Plan, Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., and Tufts Associated Health Plans, Inc., and all of their present and future affiliates. This Authorization also applies to vendors acting on behalf of the above-named entities.

1. CarePartners of Connecticut is making this disclosure for the purpose of fulfilling the request of the Member.
2. CarePartners of Connecticut will not condition treatment, payment, enrollment or eligibility for benefits on whether Member signs this Authorization.
3. CarePartners of Connecticut will disclose Member's information in accordance with this Authorization. Once the information is disclosed according to this Authorization, it is no longer protected by HIPAA and may be redisclosed by the Recipient.
4. Member has a right to receive a copy of this Authorization.
5. Unless indicated here, this Authorization will remain in effect for two (2) years from the date of signature on this form (or, for a minor, the day before the minor's 18th birthday, whichever is earlier). If Member desires an alternate end date, please specify a date here: _____.
6. Member may revoke this Authorization in writing at any time prior to its termination, except to the extent that information has already been disclosed while this Authorization was in effect.
7. This Authorization allows for the disclosure of information to the Recipient named above, but it does not allow the Recipient to access Member's information through Member's online account.

I have read and understand the terms of this Authorization and I hereby authorize the disclosure of my information in the manner described above. I represent that the signature below is my own and that I am legally authorized to sign this document.

Signature of Member or Personal Representative**	**Date**
Printed Name	**Relationship, if not Member****

**This Authorization will only be valid if signed by Member, the parent or guardian of Member if Member is a minor (unless Member is age 12-17 and the authorization includes information in protected categories), or Member's Personal Representative (e.g., power of attorney, health care proxy, etc.). If you are not Member, please indicate your relationship to Member above and submit a copy of the applicable legal documentation if you are a Personal Representative (if not already provided).

Please return completed form and supporting legal documentation (if applicable) to:

Via FAX:	**Via MAIL:**
ATTN: Member Services Department 1-617-972-9405	CarePartners of Connecticut Member Services Department P.O. Box 494 Canton, MA 02021

If you have any questions about this form, please contact a CarePartners of Connecticut Member Services representative at the number listed on the back of your Member ID card.