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Well Sense Health Plan Release of Information Form

IMPORTANT: Well Sense Health Plan is a managed care organization, not a medical provider. The company does not provide medical treatment or maintain treatment records concerning Well Sense Health Plan members. Well Sense Health Plan processes claims submitted by medical providers and maintains records of such claims. Requests for medical records must be directed to medical providers. All fields are required. Incomplete or incorrect forms will be returned. The provision of payment by Well Sense Health Plan for covered services, enrollment in Well Sense Health Plan, or eligibility for benefits through Well Sense Health Plan is not conditioned on this authorization.

Member Information (Please print information clearly)

YOUR MEMBER ID NUMBER (FOUND ON YOUR WELL SENSE HEALTH PLAN ID CARD)			
MEMBER'S LAST NAME			
FIRST NAME	MIDDLE INITIAL		
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

Recipient (person or organization that will receive your information)

I hereby authorize Well Sense Health Plan to release my protected health information by mail to:	
PERSON'S NAME OR ORGANIZATION:	PHONE NUMBER:
ADDRESS	

Description of the Information to be Released (what type of information will be released)

Check all boxes that apply:

☐ **Designated Record Set** **From:**____________**To:**____________

(consist of enrollment, claim information, pharmacy utilization management, care management)

☐ **Appeals Benefit Decision Documents** **Final Decision date:** ______________

☐ **Third Party Liability** **From:**____________**To:**____________

☐ **Member Service call log Information** **From:**____________**To:**____________

☐ **Co-payment information**__________________________ **From:**____________**To:**____________

☐ **Others (please list)** ______________________________

Purpose of Release: ____

Examples: At my request; To resolve my appeal; To assist with my health insurance services

Special Categories

Federal and state law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for BMC HealthNet Plan to release any of the following information by **initialing all that apply.**

GENETIC TESTING AND RESULTS		**SEXUALLY TRANSMITTED DISEASES(STD)**	
MENTAL / BEHAVIORAL HEALTH		**SEXUAL ASSAUALT**	
DOMESTIC VIOLENCE		**FAMILY PLANNING**	
CARE AND TREATMENT OF PREGNANT MINOR		**SUBSTANCE/ALCOHOL ABUSE**	
HIV/AIDS		**ABORTION**	
MAMMOGRAPHY REPORTS			

Expiration

This authorization will remain in effect until the termination of my enrollment in Well Sense Health Plan or until I provide a written notice of my revocation to Well Sense Plan at the address listed below, whichever occurs first. I understand that my revocation of my authorization to Well Sense Health Plan for the release of my information as described above will be effective upon Well Sense Health Plan's receipt and processing of my written revocation and that the revocation will not be valid where Well Sense Health Plan has already acted in reliance upon my designation.

I understand that my alcohol and/or drug treatment records are proteced under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 41 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided by law. I understand that, upon request, I must be provided a list of entities to which my alcohol and/or drug treatment information has been disclosed.

Approval (You OR your personal Representative must sign and date this form in order for it to be complete)

Member Signature: I have read and understand the terms of this authorization and I have had the opportunity to ask questions about these and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize disclosure of my health information in the manner described above.

Personal Representative Information: A personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

Signature of Member/Personal Representative　　　　Date

Print Name

Mail or Fax completed form to:

Well Sense Health Plan
ATTN: Privacy Officer
1155 Elm Street, Suite 600
Manchester, NH 03101
Fax: 617-897-0884