Release of Information Form

WellSense HEALTH PLAN

How to Use This Form: You can use this form to request your personal health record or provide WellSense with permission to release your health information to a third party.

Important: WellSense Health Plan is a managed care organization, not a medical provider. The company does not provide medical treatment or maintain treatment records concerning WellSense members. WellSense processes claims submitted by medical providers and maintains records of such claims. Requests for medical records must be directed to medical providers. Completing this form does not impact payment for covered services, enrollment in WellSense Health Plan, or your eligibility for benefits.

All fields on this form are required. Incomplete or incorrect forms will be returned.

Member information (please print information clearly)

Your member ID number (found on your WellSense Health Plan ID card)

Member's last name

First name	Middle initial

Address	City	State	Zip code

Phone

Product Information

Please select all products that apply to you:

Massachusetts	New Hampshire
☐ MassHealth	☐ NH Medicaid
☐ Clarity plans	☐ NH Medicare Advantage HMO
☐ Senior Care Options	

Type of request

Type of Request	Instructions
☐ Initial (New)	This box is to initiate a new request and is effective upon WellSense's receipt and processing until you submit a modification or revocation. Complete entire form.
☐ Modify (Change)	This box is to modify an existing request and is effective upon WellSense's receipt and processing. Complete entire form.
☐ Revoke/End as of ________________ (mm/dd/yyyy)	This box ends an existing request and is effective upon the date you enter. WellSense is not responsible for acting in good faith prior to receipt and processing of this request. You only need to complete the Member Information, Product Information, Type of Request and Signature sections of this form.

Recipient (person or organization that will receive your information)

I hereby authorize WellSense Health Plan to release my protected health information by mail or secure email to:

Person's name or organization		Phone number
Address		
City	State	Zip code

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

Check all boxes that apply	Include time period for requested info	
☐ Designated Record Set (contains enrollment, claims, pharmacy utilization management, and care management information)	From	To
☐ Appeals Benefit Decision Documents	Final decision date	

☐ Third Party Liability	From	To
☐ Member Service Call Log Information	From	To
☐ Co-payment and cost-sharing Information	From	To

Purpose of release (why you are requesting these files)

Example: At my request; to resolve my appeal; to assist with my health insurance services, for legal purposes, etc.

Purpose

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 WellSense Health Plan to release any of the following information by **initialing all that apply**.

	Initial		**Initial**
Genetic testing and results		Sexual assault	
Mental health/behavioral health		Substance/alcohol abuse	
Domestic violence		Sexually transmitted diseases (STD)	
HIV/AIDS		Mammography Reports	
Abortion			

This authorization will remain in effect until the termination of my enrollment in WellSense Health Plan or until I provide a written notice of my revocation to WellSense Health Plan at the address listed below, whichever occurs first. I understand that my revocation of my authorization to

WellSense Health Plan for the release of my information as described above will be effective upon WellSense Health Plan's receipt and processing of my written revocation and that the revocation will not be valid where WellSense Health Plan has already acted in reliance upon my designation.

I understand that my alcohol and/or drug treatment records are protected 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 this form and the disclosure of my heath 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, Designation of Personal Representative form, 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:

WellSense Health Plan
Attn: Privacy Officer
529 Main Street, Suite 500
Charlestown, MA 02129
Fax: 617-897-0884