Release of Information Form

WellSense HEALTH PLAN

How to Use This Form: You can use this form to authorize WellSense to release your health information to a third party.

Important: WellSense is a managed care organization, not a medical provider. We do 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 with WellSense, or your eligibility for benefits. Information, including personal or reproductive health information, that is disclosed to third parties may no longer be protected by HIPAA and could be redisclosed.

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 ID card)

Member's last name

Member's first name	Middle initial	Date of birth (mm/dd/yyyy)

Address

City	State	Zip Code

Phone

Product Information

Please select all products that apply to you:

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

Type of Authorization

Type of Authorization	Instructions
☐ Initial (New)	This box is to initiate a new authorization and is effective upon WellSense's receipt and processing until the earlier of the date you submit a modification or revocation or your enrollment with WellSense ends. Complete entire form.
☐ Modify (Change)	This box is to modify an existing authorization and is effective upon WellSense's receipt and processing until the earlier of the date you submit a modification or revocation or your enrollment with WellSense ends. Complete entire form.
☐ Revoke/End as of ______________ (mm/dd/yyyy)	This box ends an existing authorization and is effective upon WellSense's receipt and processing of your written revocation and that the revocation will not be valid where WellSense has already acted in reliance upon my designation. 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 to release my protected health information by mail or secure email to:

Person's name or organization	Phone number	
Email address		
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

☐ Other (please describe):

Purpose of release (why you are authorizing 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 to release any of the following information by **initialing all that apply**.

	Initial		Initial
Abortion		HIV/AIDS	
Care/treatment of pregnant minor		Mammography	
Domestic violence		Mental/behavioral health	
Family planning		Sexual assault	
Genetic testing		Sexually transmitted diseases (STD)	
		Substance use (alcohol and drug)	

This authorization will remain in effect until the earlier of i) the end of my enrollment in WellSense or ii) until I provide a written notice of my revocation to WellSense at the address listed below. I understand that my revocation of my authorization to WellSense 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 has already acted in reliance upon my designation.

I understand that my substance use treatment records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 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 WellSense 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
100 City Square, Suite 200
Charlestown, MA 02129
Fax: 617-897-0884