Care Management PHI Form

WellSense HEALTH PLAN

A. Purpose and use of this form

What is Protected Health Information (PHI)?

PHI is any information about your health that can be linked to you and includes information such as your health status, your medical record, and your payment history. Well Sense Health Plan (the Plan) and WellSense (the System) must keep your PHI private. **Sharing PHI**

The law allows the Plan to share most of your PHI, without your authorization, for the following reasons such as:

- For health care treatment. To help you obtain the health care treatment you need.
- For payment of health care services. To pay or be paid for your health care services and to process your claims.
- For health care operations. Including managing or coordinating your health care and maintaining your health care records.

What does this form do?

- The purpose of this form is to obtain your permission, where needed, to share your PHI internally and with third parties for purposes of managing your care. For purposes of this form, "Third Parties" may include:
- Health care providers who are not already involved in your care. The Plan and the System will help you find the right type of provider and help you schedule appointments.
- Community based organizations offering services you may need, like housing or food

You may choose to not give your consent. You may also limit the type of PHI we share and with whom we share it. Your decision will not impact your enrollment in the Plan.

B. Special/sensitive PHI

We may need your consent to share sensitive PHI internally or with "third parties." Some of the special PHI listed below may apply to you. Please check the box if you give us permission to share it. Then **sign your initials.**

	Check	Initial		Check	Initial
Genetic Testing and Results	☐		HIV/AIDS	☐	
Sexually Transmitted Diseases	☐				
Alcohol/Drug Treatment Records (including claims information, identity of treating providers, laboratory results, and diagnosis and treatment information) may be shared				☐	

with the Plan and System employees and their contractors, subcontractors, and legal representatives, my care managers and care coordinators, community based organizations involved in my care, and my treating providers and their representatives, for the purposes of care coordination, care management, and treatment. I understand that my alcohol and/or drug 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 & 164, and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that, upon request, I must be provided a list of entities to which my alcohol / drug treatment information has been disclosed.		
C. Authorization to share PHI In this section, you decide how you want us to share your PHI.		
Read each statement below. Choose the one you agree with. Then check the box next to it and **sign your initials.**	**Check**	**Initial**
For purposes of managing my care, I give the Plan and the System permission to share my PHI, where lawful, with "third parties" necessary to provide services to me.	☐	
For purposes of managing may care, I give the Plan and the System permission to share my PHI with only the following third parties necessary to provide services to me: _____ _____	☐	
I do **not** give the Plan and/or the System permission to share my PHI with the following third parties: _____ _____ _____ I understand that the Plan and/or the System may not be able to coordinate certain services for me if it cannot share my PHI. Your decision will not impact your enrollment, eligibility, or benefits.	☐	
I do **not** give the Plan and/or the System permission to share my PHI with any third party. I understand that the Plan and/or the System may not be able to coordinate certain services for me if it cannot share my PHI. Your decision will not impact your enrollment, eligibility, or benefits.	☐	

Special Instructions: _____

_____

D. Expiration
This form will expire two years after I am no longer a Plan Member. This consent will remain in effect if I leave and return as a Plan Member within two years. You can also stop your authorization at any time by sending written notice of revocation or filling out and sending the Plan's Revocation of Release of Information form to the Plan at the address listed below, or by faxing your revocation to 866-409-5657. Your authorization to share your PHI ends as soon as the Plan receives and processes your revocation. It does not apply to PHI that the Plan and/or the System has already shared.
E. Approval You OR your Personal Representative must sign and date this form.
Member Signature: By signing below, I knowingly, willingly, and voluntarily authorize the Plan and the System to share my PHI as shown in this form. I have read and understand the terms of the authorization. I have been able to ask questions about this form and about sharing my PHI. (If you have questions about PHI or this form, please call 877-957-1300.)
I understand that, if the parties I authorize in Section C to receive and/or use my PHI are not subject to federal health information privacy laws, they may disclose my PHI and it may no longer be protected under federal health information privacy laws.
A Personal Representative has the legal authority to act on your behalf. Your Personal Representative must be named in a written document on file with the Plan. Such documents may include a Court Order, Power of Attorney, Guardianship, or the Plan's Personal Representative Designation Request form. You may also include such documentation along with this form.

Signature of Member/ Personal Representative_____

Print Name _____ Date_____

Member ID# _____ Member DOB (mm/dd/yyyy)_____

You can submit this form by fax or by mail.

By fax: 866-409-5657

By mail: WellSense Health Plan
Attn: Care Management
529 Main Street
Charlestown, MA 02129