Care Management
PHI Authorization Form

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. WellSense Health Plan must keep your PHI private.

Sharing PHI:

The law allows WellSense to share 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 to share your PHI 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. WellSense 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 WellSense, eligibility for benefits, nor WellSense's payment for health care services you receive.

WellSense is a managed care organization, not a medical provider. WellSense does not provide medical treatment. Requests for medical records must be directed to your medical provider(s).

B. Special/Sensitive PHI

We need your consent to share sensitive PHI 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 all that apply

	Check	Initial		Check	Initial
Abortion	☐		HIV/AIDS	☐	
Care/ Treatment of Pregnant Minor	☐		Mammography Reports	☐	
Domestic Violence	☐		Mental / Behavioral Health	☐	
Family Planning	☐		Sexual Assault	☐	
Genetic Testing and Results	☐		Sexually Transmitted Diseases	☐	
Substance Use/Alcohol Use 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.				☐	

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 WellSense permission to share my PHI with "third parties" necessary to provide services to me.	☐	
For purposes of managing may care, I give WellSense permission to share my PHI with only the following third party necessary to provide services to me: _____ _____	☐	

I do **not** give WellSense permission to share my PHI with the following third party: _____ _____ I understand that WellSense 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 WellSense permission to share my PHI with any third party. I understand that WellSense 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 remains in effect until you are no longer a member of WellSense. You can also stop your authorization at any time by sending written notice of revocation or filling out and sending WellSense's Release of Information form to WellSense at the address listed below, or by faxing your revocation to 617-951-3426. Your authorization to share your PHI ends as soon as WellSense receives and processes your revocation. It does not apply to PHI that WellSense 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 WellSense 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 866-853-5241.)

I understand that, if the third parties I authorize in Section C to receive and/or use my PHI are not subject 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 WellSense. Such documents may include a Court Order, Power of Attorney, Guardianship, or WellSense Personal Representative

Designation Request. You may also include such documentation along with this form.

Signature of Member/ Personal Representative _____

Print Name _____ Date _____

You can submit this form by fax or by mail.

By fax:
617-951-3426

By mail:
WellSense Health Plan
ATTN: Care Management
529 Main Street, Suite 500
Charlestown, MA 02129