AUTHORIZATION OF PERSONAL REPRESENTATIVE FORM

One Monarch Place, Suite 1500, Springfield, MA 01144-1500
Phone: 855-644-1776 • Enrollment Fax: 413-233-2635

Member Information

Member ID#: MM			(9-digit ID # with 2-digit member #)
Member Name *(First, Last)*:			
Address:	City:	State:	Zip:
Phone *(Home)*:	Date of Birth:		

Representative Information

Representative Name *(First, Last)*:			
Address:	City:	State:	Zip:
Phone: Home:	Cell:	Work:	
Relationship to Member:			

Member Authorization

I authorize Minuteman Health to disclose health information to my Personal Representative:

☐ **All information except the types of Sensitive Health Information listed below.**

SENSITIVE HEALTH INFORMATION - check the boxes you wish to authorize.
(Minors[1] please check types of information authorized if ***Minuteman Health*** *is to share this information.)*

☐ Abortion ☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Pregnancy
☐ AIDS/HIV ☐ Genetic Testing ☐ Physical Abuse ☐ Sexually Transmitted Diseases

☐ **Only the information specified (type(s)/date(s))**:
Purpose: ☐ **Any and all** ☐ Grievance/Appeal only ☐ Other:

Terms of this Authorization

a. I understand that once my information is disclosed to my Personal Representative, Minuteman Health cannot guarantee that my Personal Representative will not redisclose my health information to a third party, and that state and federal laws may no longer protect such information.

b. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Minuteman Health's treatment of me, enrollment in the health plan, or eligibility for benefits.

c. **I understand that this authorization will remain in effect until: ____________________ (date) or (if no date is provided) until I provide written revocation notice to the address listed below.** The revocation will be effective immediately upon Minuteman Health's receipt and processing of my written notice, except that the revocation will not have any effect on any action taken in reliance on my Authorization before Minuteman Health received my written notice of its revocation.

I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize Minuteman Health to use or disclose my information in the manner described above.

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Signature of Individual Authorizing Release of Health Information **Date**

If Individual is a minor or is otherwise unable to sign, please sign and complete below. (If other than "parent," please attach documentation, such as court appointment, health care proxy, etc.)

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Signature of Authorized Legal Guardian, Health Care Agent, or other Personal Representative **Relationship** **Date**

[1] MA and NH state law allow unemancipated minors of a certain age to consent to certain types of treatment.

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Note to recipients of substance use disorder information, if applicable: This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Please return completed form to: Minuteman Health, Attention: Enrollment Department, 1 Monarch Place, Suite 1500, Springfield, MA 01144-1500 **(Fax: 413.233.2635)**