Minuteman Health

One Monarch Place • Suite 1500
Springfield, MA 01144-1500
Phone 855.MHI.1776
Enrollment Fax 413.233.2635

AUTHORIZATION OF PERSONAL REPRESENTATIVE FORM

1.

Member ID #:		(9-digit ID # with 2-digit member #)	
Member Name:			
Home Address:			
Home Telephone:		Date of Birth:	

2.

Representative Name:			
Address:			
Telephone:	Home:	Cell:	Work:
Relationship to Member:			

3. **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. (Members age 12 and older must check types 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))**:

4. **Purpose:** ☐ **Any and all** ☐ Grievance/Appeal only ☐ Other: _____

5. **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.

6. **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.**

SIGN HERE _____ _____

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

7. **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.)**

SIGN HERE _____ _____ _____

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

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