HealthPlans, Inc.

MEMBER AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Please call **800-532-7575** if you need assistance or have questions.

(Please Print)

Member Name			
Member ID#		Social Security# (optional)	
Home Address			
Home Telephone		Date of Birth	

INFORMATION BEING REQUESTED

As detailed below, I hereby authorize Health Plans, Inc. (Health Plans), as Claims Administrator of my Employee Health Benefit Plan, to obtain my Protected Health Information from the "Person(s)" indicated to be used for the purpose indicated.

Protected Health Information to obtain (Be specific, including types of information and dates.)	
Name of "Person(s)" providing Protected Health Information	
Role of "Person(s)"	
Address of "Person(s)"	
Purpose ("at my request" is a sufficient answer)	

TERMS OF THIS AUTHORIZATION

1. I understand that my Employee Health Benefit Plan will not condition my treatment, enrollment or eligibility for health insurance benefits on my signing of this Authorization.
2. I understand that Health Plans will not use or re-disclose the Protected Health Information obtained for any purpose not indicated on this Authorization.
3. I understand that I have a right to receive a copy of this Authorization upon request.
4. I understand that I may revoke this Authorization in writing at any time.
5. I understand that this Authorization will remain in effect until _____ **(enter date or event here)** or until I revoke this Authorization in writing.

I have read and understand the terms of this Authorization and I hereby authorize the use and release of my Protected Health Information in the manner described in this Authorization.

Signature*	**Date**	**Printed Name***

*This Authorization will only be valid if it is signed by the member, the legal guardian of a member that is a minor, or by an individual that has a Designated Personal Representative form on file for this member. If you are not the member, please indicate your relationship to the member:

- ❑ **Legal guardian of the minor member. Relationship to minor:** _____
- ❑ **Designated Personal Representative.**

After you have completed this form please return it to: Health Plans, Inc., P.O. Box 5199, Westborough, MA 01581, Attention: Claims Department.