Authorized Personal Representative Designation Request Form

Mass General Brigham Health Plan

Bold denotes required fields.

A. Member Information		
1. Member Name	**2. Member ID (numbers and letters)**	**3. Date of Birth**
4. Address		
5. Cell Phone Number	6. Home Phone Number	7. E-mail address
8. Primary Language	9. Subscriber Name, *if different from member*	

B. Authorized Personal Representative Information	
10. Name	11. Date of Birth
12. Mailing Address	
13. Cell Phone Number	14. Home Phone Number

15. Relationship

- ☐ Authorized Personal Representative
- ☐ Executor of Estate*
- ☐ Guardian*
- ☐ Parent
- ☐ Power of Attorney*
- ☐ Provider

** denotes supporting documentation required for processing*

16. Effective Date	**17. Termination Date**

Unless otherwise noted, this authorization remains in effect through the member's enrollment.

C. Scope of Authorization Details

Please place your initials below next to the Protected Health Information (PHI) that Mass General Brigham Health Plan can discuss with your authorized Representative. Check all that apply.

☐ 18. All information contained in my Designated Record Set maintained by Mass General Brigham, except for any specific, privileged information that I have noted in the space below:

☐ 19. All information concerning any current or future appeal or grievance that I or my designated representative initiated with Mass General Brigham Health Plan

☐ 20. Other, *please specify:*

continued

C. Scope of Authorization Details (continued)

21. Please note that Mass General Brigham Health Plan will **not** release any of the following privileged information, unless you specifically consent to its release by initiating the specific category of information

- ☐ All HIV/AIDS-related information, including test results and diagnosis
- ☐ Mention of or treatment for sexually transmitted diseases
- ☐ Mention of or treatment for pregnancy or termination of pregnancy
- ☐ Psychiatric/Psychological information
- ☐ Treatment for alcohol/drug use

22. **By submitting this form, you understand and agree that:**

A. You have the right to choose one or more persons to act on your behalf with respect to your Protected Health Information (PHI).

B. You authorize Mass General Brigham Health Plan and its contracted vendors to share your Protected Health Information with your Authorized Personal Representative as outlined above.

C. This form is **not** a Health Care Proxy and does **not** authorize your Authorized Personal Representative to make medical decisions on your behalf.

D. Once PHI is disclosed, Mass General Brigham Health Plan cannot guarantee that the Authorized Personal Representative will not re-disclose the information to a third party.

E. Modifications to the authorized permissions will require submission of a new form.

F. This authorization is voluntary and you may refuse to sign it or may revoke it at any time and for any reason by notifying Mass General Brigham Health Plan in writing. Refusing or revoking this authorization will not affect the commencement, continuation, or quality of your Mass General Brigham Health Plans' treatment, health plan enrollment, or benefit eligibility.

G. This authorization will remain in effect until either 1) the termination date you have indicated above, 2) through the end of your enrollment with Mass General Brigham Health Plan, or 3) until you provide a written notice of revocation to Mass General Brigham Health Plan.

H. If you submit a request to revoke this authorization, the revocation will be effective immediately upon Mass General Brigham Health Plans' receipt, but it will not apply to any actions taken prior to the date your request was received and processed.

D. Required Signatures

Member Signature _____ **Date** _____

Member must be at least 18 years of age or otherwise legally able to make such authorization.

Personal Representative Signature _____ **Date** _____

If someone other than the member is submitting this form, please complete the information below.

Name _____ **Relationship** _____

Address _____

Signature _____ **Date** _____

If you are a legal representative other than a parent, supporting documentation of your status must accompany this document.

Return completed form by email, mail, or fax

Email: HealthPlanCustomerService-Members@mgb.org
Print, sign, scan, and then email the completed form.

Mail: Mass General Brigham Health Plan
Customer Service Department
399 Revolution Drive, Suite 820
Somerville, MA 02145

Fax: 617-526-1985

Please allow 10 business days for processing.

Member.MassGeneralBrighamHealthPlan.org

Mass General Brigham Health Plan

Important Definitions

Appeal
A request for a health plan to review a decision on a denied benefit or payment due to clinical or administrative reasons. You may also file an appeal if you disagree with a decision by Mass General Brigham Health Plan to stop coverage for services that you are receiving.

Authorized Personal Representative
A third-party individual designated in writing to be granted the same rights as the Member when transacting with Mass General Brigham Health Plan except for any specified limitations.

Designated Record Set
A group of records maintained by or for a Mass General Brigham Health Plan that includes information contained in the enrollment, payment, claims adjudica-tion, and case management record systems, as well as any other information used in whole or in part to make decisions about you, and includes records held by Mass General Brigham Health Plans' business associates that meet the definition of a Designated Record Set.

Executor of Estate
The individual responsible for managing the affairs of a deceased person's probate estate.

Grievance
Any oral or written complaint submitted to Mass General Brigham Health Plan or one of its utilization management designees by a member about care or service you received from Mass General Brigham Health Plan or from a participating provider. This type of complaint concerns the service you receive or the quality of your care and does not involve a dispute with a coverage or payment decision.

Guardian
A person who has the legal authority (and the corresponding duty) to care for the personal and property interests of another person.

Health Care Proxy
A legal document that allows a person to appoint someone they know and trust to make health care decisions if, for any reason and at any time, the person becomes unable to make or communicate those decisions.

Parent
The parent(s) on file with Mass General Brigham Health Plan.

Provider
A doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker authorized to practice and perform within the scope of their practice as defined by State law.

Power of Attorney
An individual granted with a legal document giving him/her the authority to act for another person in specified or all legal or financial matters and make decisions on the person's behalf.

Protected Health Information (PHI)
Any information about health status, provision of health care, or payment for health care that is created or collected by Mass General Brigham Health Plan or one of our business associates and can be linked to a specific individual.