Mass General Brigham
Health Plan

Reset

Authorization to Release Protected Health Information (PHI)

Please note: Requests not completed entirely and/or missing required signatures cannot be processed.
Bold denotes required fields.

Recipient's Information

Individual/Organization Name _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ Fax: _____

Reason/Purpose

Request Details

Please be as specific as possible above regarding which health information records are being requested and include dates of service and other relevant details.

Member's Information

Name: _____

Member ID#: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ Email address: _____

Authorization/Consent Details

Please place your initials below next to any additional Protected Health Information *(PHI) that Mass General Brigham Health Plan can release to the recipient. Check all that apply.* ***Mass General Brigham Health Plan will not release any of this privileged information unless you specifically consent to its release by initialing the specific category of information.***

_____ **I authorize Mass General Brigham Health Plan to release the specific health information/records indicated above.**

In addition, I authorize release of the following records:

_____ **All information related to HIV/AIDS including test results and/or diagnosis**

_____ **Psychiatric/Psychological information**

_____ **Mention of or treatment for sexually transmitted diseases**

_____ **Mention of or treatment for pregnancy or termination of pregnancy**

_____ **Treatment for alcohol/drug abuse**

Effective Dates

Please check the applicable box

☐ **This authorization is effective from the date of receipt by Mass General Brigham Health Plan until** _____.

Required Signatures

By submitting this form, you understand and agree that:

- ✓ Once Protected Health Information (PHI) is disclosed, Mass General Brigham Health Plan cannot guarantee that the Recipient will not re-disclose your health information to a third party.
- ✓ That you may at any time make a written request to Mass General Brigham Health Plan to inspect and/or obtain a copy of your health information.
- ✓ That you may refuse to sign it or may revoke this authorization 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 Plan treatment, health plan enrollment or benefit eligibility.
- ✓ This authorization will remain in effect until either 1) the termination date you have indicated above, 2) you have provided a written notice of revocation to Mass General Brigham Health Plan. The revocation will be effective immediately upon Mass General Brigham Health Plan's receipt of your written notice but will not apply to any actions taken by Mass General Brigham Health Plan's receipt but will not apply to any actions taken prior to the date your request was received and processed.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly, and voluntarily, authorize Mass General Brigham Health Plan to use or disclose my health information in the manner described above.

Member Signature _____ **Date** _____

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

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

Name _____ **Relationship** _____

Signature _____ **Date** _____

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

Submission Instructions

Return signed, completed form to:

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

Email:
HealthPlanCustomerService-Members@mgb.org

Fax:
617-526-1985