Mass General Brigham
Health Plan

Member records request form

Please use this form to request copies of your protected health information contained within the designated record set maintained by Mass General Brigham Health Plan.

SECTION 1: Member information

Purpose: This form is intended to gather all required information to accurately locate, verify, and process a records request in compliance with applicable privacy regulations and organizational policies. **Completion of every field is mandatory.**

For individuals requesting disclosure of their information ("member")

First name:	M.I.	Last name:	Date of birth:
Member ID number:			
Mailing address:	City:	State:	ZIP code:
Telephone number:			

SECTION 2: Recipient information

Section 2 must be completed only when the member authorizes disclosure of information to an individual or any third party. If the records are intended solely for the member's own use, this section is not required.

The member hereby authorizes Mass General Brigham Health Plan to disclose their information to the individual or entity identified below ("recipient")

Name (individual/facility):			
Street address:	City:	State:	ZIP code:
Telephone number:			

SECTION 3: Information to be disclosed

Disclosures will be limited to the minimum necessary and made only as permitted by applicable law.

The member hereby grants authorization to Mass General Brigham Health Plan to release the information specified below to the recipient (please indicate all relevant options).

- ☐ Behavioral health claims
- ☐ Medical claims
- ☐ Pharmacy claims
- ☐ Reproductive health claims
- ☐ Alcohol and substance use (including information about services provided by federally assisted substance use disorder treatment programs)
- ☐ Other (please specify)

Service dates:

From: To:

Signature of member or personal representative:	Date:
Printed name:	Relationship, if not member:

This authorization is valid only if signed by the member, their parent or guardian (if the member is a minor and not aged 12-17), or the member's personal representative. If you are not the member, state your relationship above and provide legal documentation if acting as a personal representative, unless already submitted.

For your convenience, you may mail, email, or fax your request as follows:

Mail: Mass General Brigham Health Plan
Customer Service Department
399 Revolution Drive – Suite 810
Somerville, MA 02145

Email: MGBHPCS@mgb.org **Fax**: 617-526-1985

Please allow 30 business days for processing.