BeHealthy Partnership℠

Baystate Health Care Alliance in Partnership with Health New England

Authorization of Personal Representative Form Instructions

State and federal law gives you the right to choose one or more persons to act on your behalf with respect to the health information that pertains to you. By completing the Authorization of Personal Representative form, you are telling BeHealthy Partnership that you chose the named person as your Personal Representative. This form also allows BeHealthy Partnership to disclose your Protected Health Information (PHI) to the person you choose. The signature of a minor over the age of 12 is required to authorize release of sensitive information to their parent or legal guardian. (To authorize the release, the minor must complete Section 3 and sign this form.)

If you have questions about this form, call Member Services at **(413) 788-0123 or (800) 786-9999**.

INSTRUCTIONS: Complete all sections of the form. Please type or print all responses. This form must be filled out completely to be valid.

Once completed, print and mail or fax the form to:
BeHealthy Partnership
Attention: Enrollment Department
One Monarch Place, Suite 1500, Springfield, MA 01144-1500 | Fax: (413) 233-2635

Please note: This form is available to print online at **behealthypartnership.org/forms**.

Section 1. Provide the following Member identifying information

- *Member ID# from your BeHealthy Partnership member ID card.*
- *Name, Address, Telephone and Date of Birth of member.*

Section 2. Provide the following Personal Representative identifying information:

- ***Representative Name:*** Name of the individual you are authorizing to receive your PHI
- ***Address:*** Address of your Personal Representative
- ***Telephone:*** Telephone #s (home, cell and work) of your Personal Representative
- ***Relationship to Member:*** Personal Representative's relationship to the member (for example, parent, spouse, friend or attorney)

Section 3. Provide the Type of Information that may be disclosed and any date limitations.

- ***All Information:*** Check if authorizing all PHI to be shared with your Personal Representative except for Sensitive Health Information. (Please note that you still need to check the boxes for sharing any Sensitive Information if you wish to authorize release of this information.)
- ***Sensitive Health Information:*** Check the boxes for the types of information authorized if any. Please note: The signature of a minor over the age of 12 is required to authorize release of Sensitive Health Information to their parent or legal guardian in order for BeHealthy Partnership to disclose this information. (To authorize the release, the minor must complete this section and sign the form along with the parent/guardian to be valid.)
- ***Only the information specified (type(s)/date(s)):*** Provide the type(s) of information and any date ranges authorized. For example, you may authorize BeHealthy Partnership to share information about specific claims for specific dates of service.

Section 4. Provide the Purpose of the authorization.

- ***Any and all:*** Check if you are authorizing disclosure for any and all reasons. Your Personal Representative shall have all of the rights and privileges that you have with respect to your health information, including, but not limited to, requesting authorization on your behalf for certain services, changing your Primary Care Provider, discussing your eligibility, billing or claims information, and requesting copies of your records.
- ***Grievance/Appeal:*** Check if you are only authorizing disclosure to help with an appeal or grievance. Specify in Section 3 the type of information – for example, the name of the provider and the date(s) of the denied claim or authorization you wish to appeal. Such authorization shall include the right to view any documents, including medical records, related to this appeal.
- ***Other purpose (specify):*** Specify other specific reasons for disclosure, for example, to "Help with my bill." Again, be sure to include any limits on what you want to allow us to discuss.

Section 5. Review the Terms of the Authorization and specify an end date, if appropriate. BeHealthy Partnership/Health New England has a record retention period of ten (10) years. If you do not provide an end date, this authorization will be valid for ten (10) years from the date signed. If you wish to end the authorization sooner, you must send us written notice to end the authorization. To revoke the authorization, the Revocation of Authorization form is available to print online at **behealthypartnership.org/forms**.

Section 6. Print, sign and date the form. (Please note: a minor over age 12 must sign the form here and complete Section 3 if the minor wishes to authorize a parent to receive Sensitive Information as noted above.)

Section 7. If the individual is a minor or is otherwise unable to sign (for example, due to incapacitation), the Personal Representative also needs to sign and complete this section. (If other than "parent," please attach documentation, such as court appointment, power of attorney, etc.)

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AUTHORIZATION OF PERSONAL REPRESENTATIVE FORM

1.

Member ID # (BeHealthy Partnership card #):

Member Name:

Home Address:

Home Telephone: | Date of Birth:

2.

Representative Name:

Address:

Telephone: | Home: | Cell: | Work:

Relationship to Member:

3.

Provide the Type of Information that may be disclosed and any date limitations.
I authorize BeHealthy Partnership to disclose the following health information to my Personal Representative: ☐ All non-sensitive health information

The following types of sensitive health information (check all that you authorize)*

☐ Abortion	☐ Alcohol/Substance Abuse	☐ Mental Health	☐ Pregnancy
☐ AIDS/HIV	☐ Genetic Testing	☐ Physical Abuse	☐ Sexually Transmitted Diseases

☐ **Only the information specified (type(s)/date(s)):**

**Members age 12 or older must specifically authorize each type of Sensitive Health Information that can be disclosed.*

4.

Purpose: ☐ **Any and all** ☐ **Grievance/Appeal only** ☐ **Other:** *(Specify below)*

5.

Terms of this Authorization:

a. I understand that once my information is disclosed to my Personal Representative, BeHealthy Partnership 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 BeHealthy Partnership's treatment of me, enrollment in the health plan, or eligibility for benefits.

Section 5 continues on next page

	c. **I understand that this Authorization will remain in effect until the earliest of the following: _____ (date), or ten (10) years from the signature date, or until I provide written revocation notice to the address listed below.** The revocation will be effective immediately upon BeHealthy Partnership'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 BeHealthy Partnership received my written notice of its revocation.
6.	**I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize BeHealthy Partnership to use or disclose my information in the manner described above.** _____ _____ **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, power of attorney, etc.)** _____ _____ _____ **Signature of Authorized Legal Guardian, Health Care Agent or other Personal Representative** **Relationship** **Date**

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