

TUFTS Health Plan

Authorization Form

Member Name:

Last

First

Member ID with suffix:

Date of Birth

Telephone #:

I hereby authorize Tufts Health Plan¹ to:

Use and/or

Disclose to

(Name of corporation, or if individual, name and title, and address including zip) code)

The following information about me: [Describe, in a specific and meaningful way, the information to be used or disclosed.]

For the following purpose(s): [List each purpose for which the information may be used or disclosed.]

Term: This authorization will remain in effect:

From the date of this Authorization until the following date: _____

For as long as is necessary to complete the purposes of this Authorization.

Until the following event occurs: _____

- I understand that I have a right to revoke this authorization in writing at any time and to send my written revocation to the Member Services—Privacy Rights, Tufts Health Plan, P.O. Box 9166, Watertown, MA 02471-9166.
- I understand that the revocation will not apply to information that Tufts Health Plan has already used or disclosed in reliance on this Authorization.
- I understand that the information may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.
- I understand that Tufts Health Plan will not condition payment or my enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure.

Signature of member or Legal Representative of the member

Date

If signed by a Legal Representative, please describe your authority to act for the member and attach appropriate documentation verifying legal authority.

¹ For purposes of this Authorization, Tufts Health Plan refers to Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., and Tufts Insurance Company.