



HEALTH NEW ENGLAND, INC.
AUTHORIZATION OF PERSONAL REPRESENTATIVE FORM

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 this form you are telling Health New England, Inc. ("HNE") of your wish to choose the named person as your Personal Representative. This form also authorizes HNE to disclose your Protected Health Information ("PHI") to the person indicated.

INSTRUCTIONS: Please print all responses complete both the front and back of this form. This form must be filled out completely in order to be valid. Once completed mail or fax (413) 233-2655 the form to:

HEALTH NEW ENGLAND, INC.
One Monarch Place
Springfield, MA 01144-1500
Attn: Enrollment Department

A. MEMBER INFORMATION

Your Name: Last First Middle

Home Address:

Home Telephone: Date of Birth:

HNE Member ID Number: [] [] [] - [] [] - [] [] [] [] - [] []

B. PERSONAL REPRESENTATIVE SECTION

Name of person to whom you are authorizing HNE to disclose your PHI. (If you wish to choose more than one Personal Representative, please fill out a separate form for each person.):

Last First Middle

Address:

Telephone:

C. HEALTH INFORMATION SUBJECT TO THIS AUTHORIZATION

By signing this form you agree to allow HNE to disclose to your Personal Representative the following information:

- Enrollment/Eligibility/Billing information (such as name, address, employer group, effective date, etc.).
Claims Information (which may include diagnosis, procedures performed, providers seen, information in appeals files and case management records), subject to any restrictions set forth below.

In addition, I authorize HNE to disclose the following types of sensitive information (check all that apply):

- Information related to mental health treatment.
Information related to sexually transmitted disease(s).
Information related to treatment for substance abuse.
Information related to AIDS, ARC or HIV (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

D. PURPOSE OF THE DISCLOSURE

HNE may disclose my PHI to my Personal Representative for the following purposes: **(check only one)**

Any and All Purposes. My Personal Representative shall have all of the rights and privileges that I have with respect to my health information, including, but not limited to, requesting authorization on my behalf for certain services, changing my Primary Care Physician, discussing my eligibility, billing or claims information, and requesting copies of my records.

Appeal Purposes Only. My Personal Representative is authorized to assist and represent me during the appeal process regarding the denial of services I received from _____(Name of Provider) on _____(Date of Denial). Such authorization shall include the right to view any documents, including medical records, related to this appeal.

Other. My Personal Representative may act on my behalf for the following purpose only (please specify):

E. TERM

This Authorization will remain in effect: **(check only one)**

From the date shown below until _____ (insert date).

Until revoked by me in writing.

Until the appeal process described above is complete (for use only in connection with an appeal).

I understand that once HNE discloses my health information to my Personal Representative, HNE 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.

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 HNE's treatment of me, enrollment in the health plan, or eligibility for benefits.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the HNE Enrollment Department at the address listed below. The revocation will be effective immediately upon HNE's receipt and processing of my written notice, except that the revocation will not have any effect on any action taken by HNE in reliance on my Authorization before it received my written notice of its revocation.

I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize HNE to use or disclose my health information in the manner described above.

Signature of Individual

Date

If Individual is a minor or is otherwise unable to sign this Authorization, please sign and complete below. (NOTE: If relationship is other than "parent" please attach appropriate documentation, such as copy of court appointment, health care proxy, etc.)

Signature of authorized Legal Guardian, Health Care Agent or other Personal Representative

Relationship

Date