Permissions for Use of Protected Health Information

WellSense HEALTH PLAN

A. Purpose and use of this form

Government regulations require WellSense Health Plan (WellSense) to obtain members' permission to use and disclose their Protected Health Information (PHI). PHI is defined by various Federal and State regulations, but generally refers to health-related information that is created by a health care provider (e.g., your medical records); a health plan (e.g. care management notes or telephone logs); or a health care clearinghouse (e.g., claims information). With your permission, WellSense will use your PHI to provide coverage for health care services to you, including sharing your PHI with other parties of your Primary Care Team (PCT) including an NCQA Accredited Managed Behavioral Health Organization (MBHO). This form allows you to grant WellSense permission to use and disclose your PHI, and also allows you to place restrictions on that permission.

Note: Federal and State regulations provide additional protections for you and constraints on use or disclosure of PHI beyond the permissions or limitations documented in this form. Federal and State regulations provide WellSense the right to use your PHI for Treatment, Payment, and Operations purposes. This form is not intended to supersede those rights.

B. Member information

Name (last, first, middle initial)		DOB (mm/dd/yyyy)	Member ID number
Address			
City	State	Zip code	Phone

C. Permissions for using and receiving information

Indicate your permission regarding the types of information WellSense can receive and use by checking the box and initialing where indicated below.

#	Check	Initial here	I grant WellSense Health Plan permission to...
1	☐		...receive and use any and all of my PHI.
2	☐		...receive and use my PHI except as indicated in Section E below.
3	☐		I withhold my permission for WellSense to receive or use my PHI. I understand that without permission to receive and use my PHI, WellSense may not be able to provide coverage for health care services for me.

D. Permissions for disclosure of information to other parties

Indicate your permission regarding to whom WellSense can disclose your PHI (for reasons other than treatment, payment, and operations which do not require your permission).

#	Check	Initial here	I grant WellSense permission to...
1	☐		...disclose my PHI to any and all third parties WellSense deems necessary to provide services to me, including the members of my PCT, state agencies, and others.
2	☐		...disclose my PHI to third parties except as indicated in Section F below.
3	☐		I withhold my permission to disclose my PHI to individuals and organizations outside of WellSense. I understand that without permission to disclose my PHI, WellSense may not be able to provide coverage for health care services for me.

E. Restrictions/limitations on receipt and use of PHI

If you selected Option #1 or Option #3 in Section C, skip this section. If you selected Option #2 in Section C, use this space to indicate the types of receipt or use limitations you wish to impose.

I withhold my permission for WellSense to receive or use the following types of PHI:

F. Restrictions/limitations on disclosure of PHI

If you selected Option #1 or Option #3 in Section D, skip this section. If you selected Option #2 in Section D, use this space to indicate the types of disclosure limitations you wish to impose.

G. Sensitive condition information

Federal and State regulations create special protections for certain types of information about sensitive conditions. WellSense must obtain your permission, in addition to permissions granted in Sections C and D above, to share information about any of the conditions described in this section. To grant permission for WellSense to use or disclose this information, you must check and initial each box, and you (or your personal representative) must sign where indicated below.

☐	AIDS/ARC and/or HIV test results	☐	Genetic testing
☐	Alcohol and/or substance use	☐	Mammography Reports
☐	Behavioral health	☐	Sexual assault
☐	Domestic violence	☐	Sexually transmitted diseases

Member Signature	Date
Personal Representative Signature	Date

H. Personal representative

If you have given someone else permission to act on your behalf or to be your personal representative, please provide evidence of that authority by providing a copy of the Court Order, Guardianship, or Power of Attorney, etc. or inform us that you have a Designation of Personal Representative on file.

In the space below, please provide a brief description of your delegation of authority.

I. Signature

I understand that the permission(s) I grant to WellSense will remain in effect until I am no longer enrolled with WellSense or I revoke said permission by writing to my Care Manager at WellSense at the address shown below, whichever occurs first. I understand that any revocation of my permission will only be effective on the fourth (4th) business day following WellSense Health Plan's receipt of my written revocation and that the revocation will not be valid where WellSense may have already acted in reliance upon my permission.

By signing below, I acknowledge that I have read and understand the terms of this authorization, and have had the opportunity to ask questions and obtain answers to questions about this authorization regarding use and disclosure of my Protected Health Information. I hereby knowingly and voluntarily, authorize use and disclosure of my Protected Health Information in the manner described above.

Member Signature

Date

Personal Representative Name (please print)

Relationship to Member (parent/guardian)

Signature of Personal Representative

Mail completed form to:

WellSense Health Plan
Attn: Member Enrollment
529 Main Street, Suite 500
Charlestown, MA 02129

WellSense Senior Care Options (HMO SNP) is an HMO plan with a Medicare Advantage contract and a contract with the Massachusetts Medicaid program. Enrollment in WellSense Senior Care Options (HMO SNP) depends on contract renewal. WellSense Senior Care Options (HMO SNP) is a voluntary MassHealth (Medicaid) program in association with the Executive Office of Health and Human Services and the Centers for Medicare & Medicaid Services. WellSense complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-833-8125 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855-833-8125 (TTY: 711).