



# BMC HealthNet Plan Release of Information Form

bmchp.org | MA Health: 888-566-0010  
QHP including ConnectorCare: 855-833-8120

**IMPORTANT:** Boston Medical Center HealthNet Plan is a managed care organization, not a medical provider. The company does not provide medical treatment or maintain treatment records concerning BMC HealthNet Plan members. BMC HealthNet Plan processes claims submitted by medical providers and maintains records of such claims. Requests for medical records must be directed to medical providers. All fields are required. Incomplete or incorrect forms will be returned. The provision of payment by BMCHP for covered services, enrollment in BMCHP, or eligibility for benefits through BMCHP is not conditioned on this authorization.

<b>Member Information</b> (Please print information clearly)			
YOUR MEMBER ID NUMBER (FOUND ON YOUR BMC HEALTHNET PLAN ID CARD)			
MEMBER'S LAST NAME			
FIRST NAME		MIDDLE INITIAL	
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

<b>Recipient</b> (person or organization that will receive your information)	
I hereby authorize BMC HealthNet Plan to release my protected health information by mail to:	
PERSON'S NAME OR ORGANIZATION:	PHONE NUMBER:
ADDRESS	

<b>Description of the Information to be Released (what type of information will be released)</b>	
<b>Check all boxes that apply:</b>	
<input type="checkbox"/> <b>Designated Record Set</b> (consist of enrollment, claim information, pharmacy utilization management, care management)	From: _____ To: _____
<input type="checkbox"/> <b>Appeals Benefit Decision Documents</b>	Final Decision date: _____
<input type="checkbox"/> <b>Third Party Liability</b>	From: _____ To: _____
<input type="checkbox"/> <b>Member Service call log Information</b>	From: _____ To: _____
<input type="checkbox"/> <b>Co-payment information</b> _____	From: _____ To: _____
<input type="checkbox"/> <b>Others (please list)</b> _____	
<b>Purpose of Release:</b> _____	
Examples: At my request; To resolve my appeal; To assist with my health insurance services	

<b>Special Categories</b>	
Federal and state law may require that you give specific permission to release the information below even if you checked a box above. Indicate your permission for BMC HealthNet Plan to release any of the following information by <b>initialing all that apply</b> .	
<b>GENETIC TESTING AND RESULTS</b>	<b>SEXUALLY TRANSMITTED DISEASES(STD)</b>
<b>MENTAL/ BEHAVIORAL HEALTH</b>	<b>HIV/AIDS</b>
<b>ALCOHOL/DRUG TREATMENT RECORDS</b>	
<b>Expiration</b>	
This authorization will remain in effect until the termination of my enrollment in BMC HealthNet Plan or until I provide a written notice of my revocation to BMC HealthNet Plan at the address listed below, whichever occurs first. I understand that my revocation of my authorization to BMC HealthNet Plan for the release of my information as described above will be effective upon BMC HealthNet Plan's receipt and processing of my written revocation and that the revocation will not be valid where BMC HealthNet Plan has already acted in reliance upon my designation.	
<b>Approval (You <u>OR</u> your personal Representative must sign and date this form in order for it to be complete)</b>	
<b>Member Signature:</b> I have read and understand the terms of this authorization and I have had the opportunity to ask questions about these and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize disclosure of my health information in the manner described above.	<b>Personal Representative Information:</b> A personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

\_\_\_\_\_  
Signature of Member/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**Mail or Fax completed form to:**

BMC HealthNet Plan  
ATTN: Privacy Officer  
529 Main Street, Suite 500  
Charlestown, MA 02129  
Fax: 617-897-0884