Care Management
PHI Authorization Form

WellSense HEALTH PLAN

How to Use This Form

Completing this form will authorize WellSense Care Management to:

- Share your Protected Health Information (PHI)* with healthcare providers, third parties or community organizations (housing, food, schools).
- Receive your PHI from your other healthcare providers and their agents.
- Receive Personal Information about you from third parties and community organizations.

This information is only used to support your care which may include connecting you with local resources, coordinating care between your different providers, and more.

Member information (please print information clearly)

Your member ID number (from your WellSense ID card)

Member's last name

Member's first name	Middle initial	Date of birth (mm/dd/yyyy)

Address

City	State	Zip Code

Phone (optional)

Plan information

Please select all plans this authorization applies to:

Massachusetts

- ☐ MassHealth
- ☐ Special Kids/Special Care
- ☐ Clarity plans
- ☐ Senior Care Options

New Hampshire

- ☐ NH Medicaid
- ☐ NH Clarity plans
- ☐ NH Medicare Advantage

*PHI includes any information about your health, like your health status, medical records, or payment history as defined by HIPAA and may also include alcohol and substance use disorder records under 42 C.F.R. Part 2.

Special Instructions for who we can share your PHI with

I authorize WellSense to share my PHI with the health care providers and third parties involved in my care and receive personal information from those same providers and third parties for the purposes of managing my care.

If there are specific providers or third parties with whom you want us to share or not share your PHI or other special instructions, please list them here:

Share with:_____

Do not share with:_____

Please note: Your choice to exclude certain providers or third parties won't affect your enrollment, benefits, or payments by WellSense for your healthcare.

Permission for sharing my sensitive PHI (please initial all that apply)

Under federal and state law, WellSense needs your consent to share sensitive PHI with third parties. Please initial next to the sensitive PHI category that you give WellSense permission to share.

	Initial		**Initial**
Abortion		HIV/AIDS	
Care/ Treatment of Pregnant Minor		Mammography Reports	
Domestic Violence		Mental / Behavioral Health	
Family Planning		Sexual Assault	
Genetic Testing and Results		Sexually Transmitted Diseases	
Substance Use/Alcohol Use (including treatment records protected under Federal regulations, 42 C.F.R. Part 2).			

Revoking permission to share my information

This authorization will end on the date provided below OR if my enrollment in WellSense ends.

☐ Only share my information until this date (MM/DD/YY): _____

I am aware that I may provide written notice to WellSense at any time stating that I am revoking my permission. This notice should be sent to the address on the last page. I understand that revoking permission will take effect once WellSense receives and processes my request. If information has already been shared per my previous request, I understand that WellSense is unable to pull that information back.

I understand that my substance use treatment records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided by law. I understand that, upon request, I must be provided a list of entities to which my alcohol and/or drug treatment information has been disclosed.

Approval (You or your personal representative must sign and date this form to complete it)

Member signature I have read and understand the terms of this authorization and I have had the opportunity to ask questions about this form and the disclosure of my heath information. By my signature below, I hereby, knowingly and voluntarily, authorize disclosure or receipt of my health information in the manner described above.	**Personal representative information** 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, Designation of Personal Representative form, or other legal document must be on file at WellSense or submitted with this form.
Signature of Member/Personal Representative	Date
Print Name	

Form submission

You can submit this form by fax, email, or by mail.

By fax
Massachusetts: 617-951-3426
NH: 866-409-5657

By mail
WellSense Health Plan
ATTN: Care Management
100 City Square, Suite 200
Charlestown, MA 02129

By email

Massachusetts: CM.Tel@Wellsense.org
NH: NHCare.Management@Wellsense.org

Please note: email is not a secure way to transfer information.

If you have questions about PHI or this form please call 866-853-5241 (for Massachusetts members) or 855-833-8119 (for New Hampshire members)