Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

GROUP INSURANCE COMMISSION
Authorization for Release of Health Information

I, _____ at (address) _____,
give permission to (name of covered entity)_____ to release to a representative of the Group Insurance Commission the following information about me for the following reasons:

Information:	**To be used for*:**
_____	_____
_____	_____

*If you do not wish to state a purpose, please state, "At the request of the individual."

OR

I, _____ at (address) _____,
give permission to a representative of the Group Insurance Commission to release to _____ the following information about me for the following reasons:

Information:	**To be used for*:**
_____	_____
_____	_____

*If you do not wish to state a purpose, please state, "At the request of the individual."

(1) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the Group Insurance Commission in writing at P.O. Box 8747, Boston, MA 02114. I understand that the revocation is only effective after the Group Insurance Commission receives and logs it. I understand that the revocation does not apply to any use or disclosure made prior to revoking my authorization.

(2) I understand that the Group Insurance Commission might make use or disclosure of information that I authorized prior to my revocation of the authorization.

(3) I understand that I do not have to agree to release this information in order to be eligible for continued benefits that I am entitled to, as long as my eligibility for those benefits can be determined without releasing that information.

(4) I understand that after this information is disclosed, federal law may not protect it and the recipient may re-disclose it.

(5) I understand that I am entitled to receive a copy of this authorization.

(6) I understand that once the information has been given out for the stated purpose, my permission for the release ends.

Signature of Enrollee/Personal Representative: _____

Date: _____

If a Personal Representative for an enrollee executes this form, indicate below the nature of the authority to sign this form on the enrollee's behalf:

_____

Witness: _____ Date: _____

GROUP INSURANCE COMMISSION

AUTHORIZATION REVOCATION

Name:_____ Address:_____

SS#: _____ DOB: _____

I hereby revoke the Authorization for Release of Information that was signed by me or my Personal Representative on _____(date), for _____ _____ and _____ to share protected health information.

I understand that this revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ _____
Signature of individual or Personal Representative Date

_____
Print name

Indicate relationship of person signing this form to the individual
[ ] Person signing is the individual
[ ] Person signing is the Personal Representative authorized to make medical decisions for the individual. Type of authority (e.g., court appointed, custodial parent) _____ _____.

A COPY OF THIS FORM SHOULD BE GIVEN TO THE GIC AND THE OTHER PERSON/FACILITY/AGENCY.