Commonwealth of Massachusetts
Group Insurance Commission

Authorization for Release of Health and/or Other Information*

Purpose of this form: This form allows GIC members to authorize the GIC and its staff to speak with the person(s) you designate about the information you select. **This form does not allow that person to make changes to your account**, on your behalf. It is specific to the GIC and only applies to information at the GIC.

IMPORTANT: This form must be <u>fully completed</u> or it will not be accepted.
I, _____ (Your Name) residing at
_____
_____(Your Address) give permission to the Group Insurance Commission and its representatives (GIC) to release the following information about me to _____ (Name of Person or entity you wish the GIC to share information with) for the reason(s) described below:

<u>Information that I wish to share:</u>
□ All information that the GIC has about me, including Protected Health Information (PHI)
□ All information about my healthcare benefits
□ All information about my life insurance benefits
□ All information about my vision benefits
□ All information about my dental benefits
□ All information as requested by my attorney. I acknowledge that, in addition to this form, my attorney must send in a signed letter of representation.
□ Information that I define below:
_____
_____
_____
_____

<u>The information indicated above will be used for:</u>
(If you do not wish to state a purpose, please write, "At the request of the individual.")
_____
_____
_____
_____

This authorization expires on _____ (indicate date or N/A) or when the following event occurs
_____.
Please note: The GIC reserves the right to request another authorization form, annually.

1. Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the GIC in writing at P.O. Box 556, Randolph, MA 02368. I understand that the revocation is only effective after the GIC's Legal Department receives it, reviews it, and accepts it (evidenced by logging it in the member's record). I understand that the revocation does not apply to any use or disclosure made prior to revoking my authorization.
2. I understand that the GIC might use or disclose information that I authorize 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 such 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. If you write “at the request of the individual” instead of providing a description of limited scope or specific purpose, the person you give permission to access your GIC and HIPAA information will be able to access everything, except that which requires formal legal permission in a power of attorney (POA). Additionally, if you do not write in an end date, the GIC will keep this authorization on file until you revoke it by writing to the GIC at the above address and informing the GIC of the revocation.

Your Signature _____ Date of Signature: _____

If a Personal Representative for an individual executes this form, indicate below the nature of the authority to sign this form on the individual’s behalf. All information requested below must be provided, unless already on file with the GIC.

- If you are signing under POA, please provide a copy of the POA document with this form.
- If you are signing as the authorized HIPAA Representative, please provide evidence of your authority with this form.
- If you are signing under another capacity, please include evidence of your authority with this form.

Sending this form in signed by a Personal Representative does not guarantee that it will be honored. The GIC will review all third-party form submissions and may require additional information regarding the asserted authority prior to approval. The GIC, in its sole discretion, may decline to honor the asserted authority.

***PLEASE NOTE: All capitalized terms are defined under the Health Insurance Portability and Accountability Act (HIPAA), unless otherwise stated.**