WELLFLEET

MEMBER'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, am a Member of a health plan administered by Wellfleet Group, LLC (WELLFLEET). My Member ID number is _____ and my phone number is (____) ____-_____.

I hereby authorize WELLFLEET to release medical claim information described below to the following Recipient(s):

Recipient Name(s): _____
Recipient Phone number(s): _____

Please release my information pertaining to (**MUST SELECT ONE**):

1. ☐ any enrollment, claims status or payment information WELLFLEET has in its records.

If you are authorizing WELLFLEET to disclose information beyond claims status or payment concerning treatment for one of the conditions described below, you MUST initial the specific category you are authorizing us to disclose. WELLFLEET will not disclose such information unless you provide your initials next to the protected category to indicate YES, that you authorize us to release/disclose information to Recipient(s).

Category	Initial		Category	Initial
Abortion			Alcohol/Substance Abuse	
Reproductive Health			Behavioral Health	
AIDS/ARC			Physical Abuse	
HIV			Domestic Violence	
Communicable Disease (venereal disease)			Genetic Testing	

-OR-

2. ☐ the following specific claim (please describe the claim as accurately as possible, including dates, location of treatment, etc.):
   _____
   _____
   _____

Terms of this Authorization

1. I understand that WELLFLEET will not condition my treatment, enrollment, or eligibility for benefits under a plan, on my signing this Authorization.
2. I understand that WELLFLEET will release my information as directed by the terms and conditions of this Authorization. I understand that any information released under this Authorization is out of WELLFLEET's control once sent, and WELLFLEET has no further control over the security or use of this information.
3. I understand I have a right to receive a copy of this Authorization.
4. I understand I have a right to revoke this Authorization, but that the revocation will not apply to information already released under this Authorization.
5. This authorization shall be valid until _____, 20__. (if no date is included, Authorization shall be valid for a period of two years from date of receipt by WELLFLEET).

Send completed form to:	Wellfleet Group, LLC PO Box 15369 Springfield, MA 01115-5369 If sent by email: customerservice@wellfleetinsurance.com If sent by fax: (413) 733-4612

I have read and understand the terms of this Authorization and hereby authorize the release of the information described above, to the recipient(s) identified above.

This Authorization to Release Information form must be signed below:

Member Signature	Member's Printed Name	**Today's Date**

☐ I am a parent or legal guardian of a minor member (Relationship: _____) *
☐ I am the legally authorized representative of the member (Form of authority: _____) *

*Additional verification may be required.

Internal Use Only

Date Entered: _____ Entered By: _____