Designated Representative Form

US FAMILY HEALTH PLAN

This form may be used to designate a representative to act on a member's behalf and authorize US Family Health Plan (USFHP)* to disclose the member's protected health information to the representative.
All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.

Member Information – For individual designating a representative to act on their behalf ("Member")	
Name:	**ID Number:**
Street Address:	
City, State, Zip Code:	
Date of Birth:	**Phone Number:**

Designated Representative Information – Member hereby authorizes USFHP to disclose their information to the following individual and allow the individual to act on their behalf ("Designated Representative"):	
Name:	**Relationship to Member:**
Street Address:	
City, State, Zip Code:	
Date of Birth:	**Phone Number:**
Email Address:	

Terms of this Designation

1. Designated Representative is being appointed to act on Member's behalf with regard to certain matters related to their insurance coverage and benefits provided by USFHP. This authority includes acting on Member's behalf to receive their health information from USFHP and/or make changes related to enrollment, premium payments, benefits, claims, address changes, PCP changes, requests for special communications, and/or assistance with complaints, grievances or appeals.
2. Member's information disclosed by USFHP may include, but is not limited to, demographic information, a history of illnesses and treatments, test results, and lists of allergies and medications. Member acknowledges that the disclosure may include information in the following protected categories: abortion, AIDS/ARC, alcohol and substance abuse (including information about services provided by federally assisted substance use disorder treatment programs), behavioral health, domestic violence, genetic testing, HIV, physical abuse, reproductive health, and sexually transmitted infection testing, treatment and prevention.
3. USFHP is accepting this Designation and making associated disclosures for the purpose of fulfilling the request of Member.
4. USFHP will not condition treatment, payment, enrollment or eligibility for benefits on whether Member signs this Designation.

* For purposes of this Designation, USFHP refers to Tufts Health Plan and includes Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Point32Health Services, Inc. group health plans, Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, Tufts Benefit Administrators, Inc., Total Health Plan, Inc., CarePartners of Connecticut, Inc., and all of their present and future affiliates. This request also applies to vendors acting on behalf of the above-named entities.

5. USFHP will disclose Member's information in accordance with this Designation. Once the information is disclosed according to this Designation, it is no longer protected by HIPAA and may be redisclosed by the Designated Representative.
6. Member has a right to receive a copy of this Designation.
7. Unless indicated here, this Designation will remain in effect for two (2) years from the date of signature on this form (or, for a minor age 0-11, the day before the minor's 12th birthday, whichever is earlier), or there is a change to the member's plan that may require execution of a new form. If Member desires an alternate end date, please specify a date here: _____.
8. Member may revoke this Designation in writing at any time prior to its termination, except to the extent that information has already been disclosed while this Designation was in effect.

I have read and understand the terms of this Designation and I hereby authorize the disclosure of my information in the manner described above. I represent that the signature below is my own and that I am legally authorized to sign this document.

Signature of Member or Personal Representative**	**Date**
Printed Name	**Relationship, if not Member****

**This Designation will only be valid if signed by Member, the parent or guardian of Member if Member is age 0-11, or Member's Personal Representative (e.g., power of attorney, health care proxy, etc.). If you are not Member, please indicate your relationship to Member above and submit a copy of the applicable legal documentation if you are a Personal Representative (if not already provided).

Please return completed form and supporting legal documentation (if applicable) to:

Via FAX:	**Via MAIL:**
ATTN: Member Services 1-617-673-0380	Tufts Health Plan ATTN: Member Services - USFHP 1 Wellness Way Canton, MA 02021-1166

If you have any questions about this form, please contact a Tufts Health Plan Member Services representative at the number located on your member ID card.