

Member's Authorization to Release Information

				
eby authorize WELLFLEET to re	elease medical claim	n information described below to	the following Recipien	t(s):
pient Name(s):				
pient Phone number(s):				
se release my information pert	aining to (MUST SE	LECT ONE):		
1. any enrollment, cla	iims status or paym	ent information WELLFLEET has i	n its records.	
u are authorizing WELLELEET to	n disclose informati	on beyond claims status or paym	ent concerning treatm	ant for
_		e specific category you are autho	_	
ie conditions described below,	•		_	
not disclose such information i	inless voii nrovide v			-く tha
not disclose such information u		•	i category to indicate 41	<u>-S, tha</u>
not disclose such information u authorize us to release/disclos		•	i category to indicate Yi	<u>:S, tna</u>
		•	Initial	<u>-S, tha</u>
authorize us to release/disclos	e information to Re	cipient(s).	Initial	<u>-S, tna</u>
authorize us to release/disclos Category	e information to Re	cipient(s). Category	Initial	<u>-S, tha</u>
Category Abortion	e information to Re	Category Alcohol/Substance Abuse	Initial	<u>-S, tha</u>
Category Abortion Reproductive Health	e information to Re	Category Alcohol/Substance Abuse Behavioral Health	Initial	<u>-S, tna</u>
Category Abortion Reproductive Health AIDS/ARC HIV Communicable Disease	e information to Re	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse	Initial	<u>s, tna</u>
Category Abortion Reproductive Health AIDS/ARC HIV	e information to Re	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse Domestic Violence	Initial	<u>ss, tna</u>
Category Abortion Reproductive Health AIDS/ARC HIV Communicable Disease	e information to Re	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse Domestic Violence	Initial	<u>-S, tna</u>
Category Abortion Reproductive Health AIDS/ARC HIV Communicable Disease	e information to Re	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse Domestic Violence	Initial	ss, tha
Category Abortion Reproductive Health AIDS/ARC HIV Communicable Disease	e information to Re	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse Domestic Violence Genetic Testing	Initial	ss, tna
Category Abortion Reproductive Health AIDS/ARC HIV Communicable Disease	e information to Re	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse Domestic Violence Genetic Testing	Initial	<u>.</u> s, tna
Category Abortion Reproductive Health AIDS/ARC HIV Communicable Disease (venereal disease)	e information to Re Initial	Category Alcohol/Substance Abuse Behavioral Health Physical Abuse Domestic Violence Genetic Testing	Initial e	

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).

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:

Me	ember Signature	Member's Printed Name	Today's Date
I am the legal	or legal guardian of a minor ly authorized representative ication may be required.	r member (Relationship:e of the member (Form of authority:) *
		Internal Use Only	
	Date Entered:	Entered By:	