Martin's Point® HealthCare | US Family Health Plan

Dear US Family Health Plan Member,

Attached is the "Permission to Allow Martin's Point to Discuss My Health Care or Payment with My Designated Representative" form.

For timely processing of this form, please do the following:

- Be sure to **complete all fields** on the form, including your **signature** and the **date.**
- Check all the boxes at the top of the form that apply to your request.
- Write your Member ID number (found on your Martin's Point US Family Health Plan Member ID Card) in the box near the bottom labeled "Member ID."

Incomplete forms will be returned.

Please mail completed forms to:

Martin's Point Health Care
Attention: USFHP Member Services/HIPAA
PO Box 9746
Portland, ME 04104-5040

US FAMILY HEALTH PLAN TRICARE®

Authorization to Release Information

Permission to Allow Martin's Point to Discuss My Health Care or Payment with My Designated Representative

By signing this form, I authorize Martin's Point to discuss certain aspects of my health care and payment with a person of my choosing, known as my Designated Representative. This agreement lasts until further notice unless I request a specific time frame for this authorization to start and end. I have the right to change or end this agreement at any time. I understand that by allowing release of this information, certain aspects of my medical condition may be disclosed. I also understand that this authorization does not allow the Designated Representative to perform actions on my behalf, such as file an appeal or grievance.

☐ **I authorize Martin's Point to discuss ALL of the information (including sensitive information such as HIV/AIDS, mental health and/or substance abuse) below with my Designated Representative.**

☐ **I authorize Martin's Point to discuss with my Designated Representative ONLY the types of information I select below:**

- ☐ Appeal
- ☐ Benefits/Coverage/Authorizations
- ☐ Claim Status
- ☐ Copayment/Coinsurance Information
- ☐ Demographic Information Changes (like address, phone number)
- ☐ Grievance/Complaint
- ☐ HIV/AIDS
- ☐ Medical Care and Treatment
- ☐ Mental Health Treatment
- ☐ Pharmacy Benefit Information
- ☐ Premium/Payment Information
- ☐ Primary Care Provider Changes
- ☐ Provider Information
- ☐ Substance Abuse Treatment

DESIGNATED REPRESENTATIVE'S NAME:	**RELATIONSHIP TO ME:**
ADDRESS:	

DATE(S) THIS AUTHORIZATION IS VALID:

- ☐ No end date
- ☐ One year from signed date
- ☐ Six months from signed date
- ☐ Specific date range:

  from _____ to _____

MEMBER NAME (Please print.):	**DATE OF BIRTH:**	**MEMBER ID#**
MEMBER SIGNATURE:		**DATE SIGNED:**

For Internal Office Use Only:				
Phone Verbal Auth:	Date of Call:	Time of Call:	Scanning:	MS Initials:
Copy Provided on:				

The purpose of this form is to document an individual's agreement to allow Martin's Point to discuss their health care with a Designated Representative. To obtain paper copies of medical or other records you must complete a HIPAA authorization form, which can be obtained from Member Services. Last updated February 2017.