Clear Form

Adult Dependent's Online Account Access Form

Health Plans, Inc. (HPI) health plan members who are 18 years or older may use this form to authorize the policyholder (Subscriber) to have online access to their Protected Health Information (PHI) through HPI's member web portal.

All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.

MEMBER INFORMATION: For the individual authorizing access to their information via HPI online account to the Subscriber (Member)			
Name:		**Member ID Number:**	
Member ID Number:			
Street Address:			
City, State, ZIP Code:			
Date of Birth:		**Phone Number:**	

SUBSCRIBER INFORMATION: Member hereby authorizes HPI to disclose and provide access to their information via HPI's online account to the Subscriber on their policy.			
Name:		**Subscriber ID Number:**	
Street Address:			
City, State, ZIP Code:			
Relationship to Member:		**Date of Birth:**	

Terms of this Authorization

1. HPI is providing access to the Member's information for the purpose of fulfilling the request of the Member.
2. HPI will not condition treatment, payment, enrollment, or eligibility for benefits on whether Member signs this Authorization.
3. Member's information disclosed by HPI 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.

4. HPI will disclose Member's information in accordance with this Authorization. Once the information is disclosed according to this Authorization, it is no longer protected by HIPAA and may be redisclosed by the Recipient.
5. Member has a right to receive a copy of this Authorization.
6. Unless revoked, this Authorization will remain in effect for six (6) months after Member's HPI membership terminates.
7. Member may revoke this Authorization in writing at any time prior to its termination, except to the extent that information has already been disclosed while this Authorization was in effect.

I have read and understand the terms of this Authorization 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**

*This Authorization will only be valid if signed by Member 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 this completed form and supporting legal documentation (if applicable) to:

HPI
ATTN: Claims Department
P.O. Box 5199
Westborough, MA 01581
hpiTPA.com