Authorization to Disclose Protected Health Information

Use this form to authorize Christie Student Health* to use or disclose your protected health information.

All fields are required. Incomplete or incorrect forms will be returned.

Member Name:	**Member ID:**
Member Address:	
Member City/State/Zip:	
Member Date of Birth:	**Member Phone #:**

I hereby authorize Christie Student Health to disclose the protected health information listed below to the following person/entity:

Name:	
Relationship To Member:	**Address:**
	City/State/Zip:

Protected health information to be disclosed (describe in a specific way the information to be disclosed):

Sensitive Information: If Christie Student Health has any of the following types of information about you, you must check off the box next to the category before we can disclose the information *(information will not be disclosed unless the applicable box is checked):*

- ☐ Information related to my diagnosis and/or treatment for HIV/AIDS
- ☐ Information related to my diagnosis and/or treatment for alcohol or drug abuse
- ☐ Results of genetic testing

Describe the purpose for the disclosure (be specific, e.g., "To assist with claims payment" or you may write, "At my request"):

This authorization will remain in effect:

- ☐ From the date of this Authorization until the following date: _____
- ☐ For as long as necessary to complete the purposes of this Authorization.
- ☐ Until the following event occurs: _____

* This plan is underwritten by Tufts Insurance Company (TIC), and administered by Christie Student Health Plans LLC (CSHP). Christie Student Health is the brand name for the student health products and services provided by TIC and CSHP.

Please Note:

- You have a right to revoke this authorization in writing at any time and to send your written revocation to Christie Student Health at the address listed below. Your revocation will not apply to information that Christie Student Health has already disclosed in reliance on this Authorization.
- Information disclosed by Christie Student Health in accordance with this request may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.
- Christie Student Health will not condition payment, enrollment in the health plan, or eligibility for benefits on you providing this authorization.

Signature:

I have read and understand the above information. I represent that the signature below is my own and that I am legally authorized to sign this document.

Member, Parent, or Personal Representative* Signature

Print Name

Date

Relationship, if signed by other than Member: _____

* If not already provided, please attach legal documentation verifying personal representation.
We will require verification of the authority of a Personal Representative before this request will be considered complete.

Please Return this Completed Form and Supporting Documentation:

Fax this form

(and documentation, if applicable)

to:

781-457-7701

Or mail to: Christie Student Health
80 Hayden Avenue
Lexington, MA 02421

If you have any questions about this Authorization Form,
please contact a Christie Student Health Customer Care Representative
at:

(844) 744-9231