eternalHealth
Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information" (PHI). By completing and signing this form, I, or my legal representative, agree to allow eternalHealth to share my PHI with the people, or companies listed below. By eternalHealth, I also mean the company's affiliates, employees, agents, and subcontractors. **PLEASE COMPLETE ALL SECTIONS.**

1. My Information

First Name	Last Name	Middle Initial
Member ID Number	Date of Birth	Phone Number
Street Address		City, State, Zip

2. eternalHealth can share my PHI with the following people or companies:

Person or Company Name	Phone Number
Street Address	City, State, Zip
Person or Company Name	Phone Number
Street Address	City, State, Zip
Person or Company Name	Phone Number
Street Address	City, State, Zip

3. eternalHealth can ONLY share the following records:

You MUST check any and all information that you want to be shared. This authorization CANNOT be used to share psychotherapy notes.

- ☐ Health (medical, dental, pharmacy, and supplemental benefit information)
- ☐ Case Management records
- ☐ Substance Use Disorder (Alcohol / Drug)
- ☐ HIV/AIDS
- ☐ Sexually Transmitted Diseases
- ☐ Behavioral Health/ Mental Health (Does NOT include Psychotherapy Notes)
- ☐ Other Sensitive Services (e.g., Gender Affirming Care, Sexual or Reproductive Health)
- ☐ Other (Please Explain:

4. By signing this form, I authorize eternalHealth to disclose information for the following purpose:

Check one of the following options:

- ☐ At my request, no specific purpose.
- ☐ Specific purpose:

5. This form is valid for 1 year unless a shorter time period is listed below.

My authorization is valid from

MM/DD/YYYY MM/DD/YYYY

6. By signing below, I understand and agree:

- My PHI that I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, sexually transmitted diseases such as HIV/AIDS, and genetic marker information.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
- I can get a copy of this authorization form that I have signed by sending eternalHealth a signed request using the address at the bottom of this form.
- eternalHealth will not release my PHI to the individual(s) or company(ies) named in Section 2 unless I sign this form.

- I can cancel or change my decision any time. I can do this by writing to eternalHealth, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions eternalHealth took before getting my request.
- My ability to enroll won't change if I do not sign this form.
- My eligibility for benefits and services won't change if I do not sign this form.

Attention

My signature is required if any of the below apply:

- I am 18 or older
- I am a minor under the age of 18 and I am either married or I am emancipated
- The information being disclosed pertains to drug or alcohol treatment
- The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision: – Mental health – Sexually transmitted disease (including HIV/AIDS) – Reproductive health (including contraception, prenatal care and abortion) – General medical and dental health

7. My signature or my legal representative's signature

Signature	Date
Printed Name	
If a legal representative signed tis form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative):	

If this form is signed by a member's legal representative, you must provide documented legal authorization to allow you to act on behalf of the member (e.g., copy of the legal guardianship, power of attorney, personal representative, etc.).

Please sign and return this completed form to:

eternalHealth
PO Box 1375
Westborough, MA 01581