Termination of Authorization or Restriction

Harvard Pilgrim Health Care
a Point32Health company

This form may be used to terminate an authorization that had been granted or a restriction that was requested. **All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.**

Member Information – For the individual with Harvard Pilgrim* coverage (member) making the termination request	
Name:	**Member ID #:**
Street address:	
City, State, Zip code:	
Date of Birth:	**Phone number:**

Termination request – Member hereby requests Harvard Pilgrim to terminate the following:	
☐ Authorization to Disclose PHI	Recipient name:
☐ Designation of Representative	Representative name:
☐ Restriction Request	Restricted individual name:

Signature

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, if not member

**This Termination will only be valid if signed by member, the parent or guardian of member (if member is a minor), 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 completed form and supporting legal documentation (if applicable) to:

FAX:	**MAIL:**
ATTN: Member Services 617 509-1050	Harvard Pilgrim Health Care ATTN: Member Services 1 Wellness Way Canton, MA 02021-1166

If you have any questions about this form, please contact Member Services at the phone number on your member ID card.

*For purposes of this Termination, Harvard Pilgrim includes Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Point32Health Services, Inc. group health plans, Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, Tufts Benefit Administrators, Inc., Total Health Plan, Inc., CarePartners of Connecticut, Inc., and all of their present and future affiliates. This request also applies to vendors acting on behalf of the above-named entities.