



AUTHORIZATION TO RELEASE INFORMATION

Submitting your form

Submit your form the way you like. Mail, email or fax your claim to:

Wellfleet Insurance Company
P.O. Box 15769
Springfield, MA 01115
Fax: 413-452-5486
Email: workplaceclaims@wellfleetinsurance.com

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Care Team** at: 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information

Complete the necessary information for the claimant whose information will be released.

Name: _____
(Last, First, Middle)

Date of Birth: ____/____/____

Other Name Used: _____

Social Security Number: ____ - ____ - ____

Signature of Claimant: _____

Date signed: ____/____/____

I authorize any: licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer; to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Authorized Representative Information

Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless a parent is signing for patient under 18.

Name: _____
(Last, First, Middle)

Mailing Address: _____

Relationship to Claimant: _____

Phone: ____ - ____ - ____



Description of the information to be disclosed

I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV-related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to: employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration

Unless revoked as discussed below, this Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed or for the duration of the claim for benefits, whichever is shorter.

Right to Revoke

I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights

1. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.