Collective Health

Minor Authorization for Parent Access to Sensitive Information (For minors aged 13-17)

This form may be used by a minor health plan member aged 13-17 to authorize Collective Health to disclose Protected Health Information (PHI) about sensitive services to the member's parent or legal guardian. You must complete all the fields on this form. This form is voluntary and can be revoked at any time.

Section 1: Minor member whose information is to be released

Name: _____

Date of birth: _____ Subscriber ID: _____

Last 4 digits of Social Security #: _____ Phone: _____

Section 2: Individual to receive information

Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____

Relationship to Member: _____

Section 3: Description of the information to be shared

Any or all PHI that Collective Health maintains, including PHI regarding sensitive services, such as information regarding mental health, substance use and abuse, reproductive care (including abortion), sexually-transmitted diseases, genetic testing, etc. ("Sensitive Information").

Section 4: Revocation and expiration

You have the right to revoke this authorization at any time by notifying Collective Health in writing. Revoking this authorization will not affect disclosures made before receiving your revocation request. If not revoked, this authorization will expire on your 18th birthday. Note: Certain basic PHI (not including Sensitive Information) will continue to be accessible to your primary subscriber after revocation or expiration.

Section 5: Signature of minor member

By signing below, you hereby authorize CollectiveHealth Administrators, LLC and its parent company, subsidiaries, affiliates, and subcontractors ("Collective Health") to disclose your Sensitive Information to the parent/legal guardian named above, including through the My Collective web portal. You further acknowledge that the parent/legal guardian named above may authorize others, on your behalf, to access your Sensitive Information. Once disclosed, the Sensitive Information may no longer be protected by federal and state privacy regulations. Collective Health will not condition payment, enrollment in a health plan, or eligibility for benefits on this authorization. You have the right to receive a copy of this authorization.

Signature: _____ Date: _____

Name (print): _____

Section 6: Form submission

Submit this form to Collective Health by one of the following methods:

1. Via Secure Messages on the web (at my.collectivehealth.com) or on the mobile Collective Health app.
2. Faxing it to 1-888-974-0998.
3. Mailing it to: Collective Health, ATTN: Member Services, 1557 W. Innovation Way, Suite 300, Lehi, UT 84043.