Certification of Parental Rights

This form may be used by an individual to certify to Tufts Health Plan* that they are the parent of a member when they are not enrolled on the same policy.
All fields are required. Incomplete or incorrect forms will be returned to the parent's address provided below.

Member Information – For minor enrolled on a Tufts Health Plan ("Member")	
Name:	
Date of Birth:	**ID Number:**

Parent Information – For individual certifying their parental rights related to Member ("Parent")	
Name:	**Relationship to Member:**
Street Address:	
City, State, Zip Code:	
Date of Birth:	**Phone Number:**
Email Address:	

Terms of this Certification

1. I hereby certify that I am the parent of Member and that my parental rights have not been revoked by any legal authority.
2. I understand that I am obligated to inform Tufts Health Plan of any change in the status of my parental rights related to Member.
3. I acknowledge and agree that Tufts Health Plan may investigate my claim as the parent of Member and understand that any misrepresentation in the information provided will permit Tufts Health Plan to revoke my access to Member's information and seek other legal remedies.
4. I understand that if Member is age 12-17, I will not have access to information in the following protected categories unless Member provides specific authorization: abortion, AIDS/ARC, alcohol and substance abuse (including information about services provided by federally assisted substance use treatment programs), behavioral health, domestic violence, genetic testing, HIV, physical abuse, reproductive health, and sexually transmitted infection testing, treatment and prevention.
5. This Certification will terminate the day before Member's 18th birthday, unless earlier revoked.

I have read and understand the terms of this Certification.

Signature of Parent **Date**

Printed Name

*For purposes of this Certification, Tufts Health Plan includes Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Harvard Pilgrim Group Health Plan, Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., and Tufts Associated Health Plans, Inc., and all of their present and future affiliates. This Certification also applies to vendors acting on behalf of the above-named entities.

Please return completed form to:

Via FAX:	**Via MAIL:**
ATTN: Member Services 1-857-304-6343	Tufts Health Plan ATTN: Member Services P.O. Box 9194 Watertown, MA 02471-9194

If you have any questions about this form, please contact a Tufts Health Plan Member Services representative at: 1-888-257-1985 or TTD# 711.