American Specialty Health

AUTHORIZED PERSONAL REPRESENTATIVE

Please read this Authorized Personal Representative form carefully and fill it out completely. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

MEMBER INFORMATION

Member Name _____ Date of Birth _____

Health Plan Name _____ ID Number _____

Street Address _____

City _____ State _____ ZIP _____

Telephone _____

PERSONAL REPRESENTATIVE INFORMATION

I authorize the following individual to receive the protected health information (PHI) and exercise any related privacy rights regarding the member listed above for the purpose noted below:

Name _____

Street Address _____

City _____ State _____ ZIP _____

Telephone _____ Fax _____

PURPOSE

The purpose of this authorization is limited to the following (please describe why this information is being disclosed; attach additional pages as necessary): _____

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AUTHORIZED PERSONAL REPRESENTATIVE [CONTINUED]

INFORMATION TO BE DISCLOSED

This authorization is limited to the following PHI (choose one):

☐ All records including, but not limited to, all chart entries, diagnoses, test results, and reports.

☐ Only records relating to the following dates(s) of service: _____

☐ Only records relating to the following diagnosis/symptoms: _____

☐ Other (please explain): _____

_____

_____

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

ACKNOWLEDGEMENT & SIGNATURE

Signing this form means that I understand and agree to the following:

- I understand this Authorization is good for a period of one (1) year from the date I sign it. The Authorization will expire after that time period.
- I understand that I may revoke this Authorization at any time by notifying American Specialty Health (ASH) in writing at: Attn: Privacy Officer, American Specialty Health, 10221 Wateridge Circle, San Diego, CA 92121. If the Authorization is revoked, it will not have any effect on disclosures that were made before my notification revoking this Authorization was received by ASH.
- I understand that the Personal Representative designated above may exercise any and all privacy rights normally extended to the member identified above, including access to PHI about the member.
- I understand that disclosures to the Personal Representative designated above will include application and enrollment information, eligibility information, claims records, claims status and member medical records information including information about chronic diseases, and/or genetic marker information about the identified member.

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AUTHORIZED PERSONAL REPRESENTATIVE [CONTINUED]

ACKNOWLEDGEMENT & SIGNATURE (CONTINUED)

- I understand this authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV-RELATED INFORMATION** only if I place my initials on the appropriate line on this form in the section titled "INFORMATION TO BE DISCLOSED." In the event the health information authorized to be disclosed includes any of these types of information, and I initial the line in "INFORMATION TO BE DISCLOSED", I specifically authorize release of such information to the person (s) indicated in the "PERSONAL REPRESENTATIVE INFORMATION" section.
- If I am authorizing the release of **HIV-RELATED INFORMATION** , **ALCOHOL** or **DRUG ABUSE TREATMENT**, or **MENTAL HEALTH TREATMENT** information, the recipient may be prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.
- I understand that this Authorization is voluntary. ASH is able to provide treatment or process payment, enrollment, or eligibility for benefits without this authorization. ASH will not deny treatment, payment, enrollment, or eligibility for benefits if I do not sign this authorization, except in the case of: (a) research related treatment; (b) pre-enrollment underwriting or risk determination; or (c) provision of health care solely for the purpose of creating PHI for disclosure to a third party.
- I understand the disclosed PHI may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy law.
- I authorize American Specialty Health Incorporated and any of its parents, subsidiaries, or other affiliates that manage my benefits, to disclose PHI about the member listed above.

I hereby certify that I have read, understand and agree to the terms of this document and designate the individual listed above as the identified member's Personal Representative.

Signature ..... **Date of Signature** .....

Printed Name .....

Relationship to Member: ☐ Self ☐ Other (complete the information below)

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American Specialty Health

AUTHORIZED PERSONAL REPRESENTATIVE [CONTINUED]

ACKNOWLEDGEMENT & SIGNATURE (CONTINUED)

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation

Name .....

Street Address .....

City ..... State ..... ZIP .....

Telephone .....

Description of Representative's Authority to Act/Relationship to Member (choose one):

- ☐ Member is a minor and I am the member's parent or legal guardian.
- ☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).
- ☐ I am the member's agent, as designated in the member's Durable Power of Attorney for Health Care (please attach necessary documentation).
- ☐ Other (please describe and attach necessary documentation): .....

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RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746

Please keep a copy of this form for your records. If you need a copy, you may request one from us.