



PERSONAL REPRESENTATIVE FORM

Purpose: This form is used to confirm a Member's permission that the health plan may discuss or disclose their protected health information to a particular person who acts as their Personal Representative. Use of their information is strictly limited to that purpose described below.

Section A: Type of Information

- Personal Health Information (not including any psychotherapy notes)

Please Note: This authorization does not provide the appointed "Personal Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner, a clinical personal health care representative or a living will, please discuss this with your Primary Care physician.

Section B: Member Information

I understand that my information will be released by my health plan to the person below who I have appointed my Personal Representative. I understand that if this person is not a health plan, provider or other entity subject to federal privacy laws, they may further disclose my information and it may no longer be protected by federal privacy laws.

Member Name: _____

Address: _____

Telephone Number: () _____

Member ID Number: _____

e-mail Address: _____

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:

I authorize the discussion and / or disclosure of my personal health information to the person listed below for the purpose of assisting with or facilitating the coordination of my health insurance benefits. I understand that it is the policy of my health plan not to release my personal health information to other parties, except those directly involved in my care, without my written authorization. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that I have the right to limit the information released under this authorization. I may for example limit my Personal Representative's access to information regarding a particular provider or a particular diagnosis / disease. Any such limitations must be described here in writing.

Limitations:

Entity Authorized to Release Information:

Personal Representative:

Name:

Phone Number: ()

Address:

Section D: Expiration and Revocation

This authorization to release information to the above named Personal Representative will automatically expire 12 months from the date of signature below or upon the termination of my enrollment in the health plan. I understand that I have the right to revoke or discontinue this authorization at any time. I understand that, if I do not wish for the above named person to remain my Personal Representative, I must revoke this authorization **in writing** by giving written notice that I choose to revoke my Personal Representative authorization to the contact listed below. I understand that revocation of this authorization will not impact any action that you have taken, or any information that you have already released, based upon this authorization prior to your receiving my request to revoke it.

Contact Person:

email Address:

Address: AmeriCorps, P.O. Box 3430, Carmel, IN 46082-3430

Section E: Signature / Authorization

I, _____, have had full opportunity to read and consider the content of this Personal Representative Authorization Form. I confirm that this authorization is consistent with my request of the health plan and its administrator. I understand that, by signing this form, I am confirming my authorization that the health plan may use and / or disclose my personal health information to the person or entity named on this form for the purpose described above.

Signature:

Date:

**RETURN THE SIGNED AUTHORIZATION FORM TO THE CONTACT PERSON LISTED IN SECTION D.
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.**