

Authorized Representative

Section 1: Appointment of Authorized Representative

I appoint:

Name: _____

Address: _____

Telephone Number: _____

as my authorized representative for the purposes described in Sections 2 and 3 below. I understand this agreement is voluntary and made to confirm my direction.

I understand that my authorized representative may further disclose my information, and it may not be protected by federal or state privacy laws.

Name: _____

Address: _____

Telephone Number: _____ E-mail: _____

Identification Number: _____ Group Number: _____

Section 2: Scope of Authority

I authorize the disclosure of my protected health information to my authorized representative for the following purposes (check only one):

- Disclose my claim for claim # _____ only
- Disclose all claims related to my diagnosis of _____ only
- Disclose all claims for _____ provider only (*write name of physician or hospital*)
- Disclose all claims for _____ date(s) of service (*write specific date or span of dates*)
- Disclose all of my claims regardless of dates of service, provider or diagnosis.
- Other: _____

Section 3: Options for Disclosures

I authorize the disclosure of my protected health information to my authorized representative by the following means: (check only one):

- Disclose my protected health information by telephone only
- Disclose my protected health information by sending all original documents by U.S. mail only (*I understand that choosing this option means that all further disclosures will be given to my authorized representative.)
- Disclose my protected health information by both telephone and U.S. Mail (*I understand that choosing this option means that all further disclosures will be given to my authorized representative.)

