HIPAA Authorized Representative Form

Note: 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 Authorized Representative. Use of their information is strictly limited to that purpose described below.

Section A: Member Information

By signing this form in Section E below, I understand and agree that you, HMA, may release my personal health information as defined in Section B below to my Authorized Representative(s) named in Section C below.

Member Name: _____

Address: _____

Telephone Number: ( ) - Member ID Number:__

Email Address: _____ Social Security Number: _____

Please Note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative or if you want to set up a living will, please discuss this with your primary care physician or your attorney. Also we promise that we will not condition benefits, payments, enrollment, or eligibility for benefits on the execution of this form.

Section B: Type of Information

- Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information (but not including any psychotherapy notes).

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name: _____ Telephone: ( ) -_____

Address:

_____

_____

_____

Relationship to you: _____

Authorized Representative #2:

Name: _____ Telephone: ( ) -_____

Address:

_____

_____

_____

Relationship to you: _____

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis / disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limits on Disclosure:

_____

HMA
1600 W Broadway Rd. ♦ Suite 300 ♦ Tempe, AZ 85282
Phone 480.921-8944 ♦ Fax 866.814.3854

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire two years following the termination of my health plan enrollment.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to the health plan contact listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Contact Person: Privacy Officer

Address: HMA, LLC.

Attention: Privacy Officer

1600 W Broadway Rd., Suite # 300

Tempe, AZ 85282

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this Authorized Representative 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(s) named in Section C for the purpose described above.

Signature: _____ **Date:** _____