



**APPOINTMENT OF PERSONAL REPRESENTATIVE  
FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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For the purpose of this authorization, "Plan" or "Plans" will be defined as the (Employer Name) \_\_\_\_\_ Health Plan. Unless specifically permitted under the Plan's policies and procedures or required by law, the Plan will not use or disclose protected health information (PHI) without a valid authorization signed by the individual who is the subject of the PHI. This authorization allows the individual to name and identify personal representative(s) they wish to grant access to their protected health information to assist in their healthcare needs.

**PLEASE NOTE: In a situation where the information requested involves psychotherapy notes, an additional authorization will be required.**

**SECTION A: INDIVIDUAL AUTHORIZING USE AND/OR DISCLOSURE** *(please print)*

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_

**SECTION B: THE USE AND/OR DISCLOSURE BEING AUTHORIZED**

**Purpose Of This Authorization:** At the request of the individual, to allow the person(s) named below to assist with the individual's healthcare needs.

**Protected Health Information To Be Used And/Or Disclosed:** Information maintained by IntraHealth Solutions, Inc. in connection with benefits received under the Plans for the individual named above in Section A.

**Entities Authorized To Use Or Disclose Protected Health Information:** IntraHealth Solutions, Inc.

**Persons Authorized To Receive And Use Protected Health Information:** Please list the full name and date of birth (mm/dd/yy) for each personal representative you wish to grant access to your protected health information.

Name <i>(please print)</i>	Relationship	Date of Birth
Name <i>(please print)</i>	Relationship	Date of Birth
Name <i>(please print)</i>	Relationship	Date of Birth
Name <i>(please print)</i>	Relationship	Date of Birth

**PLEASE NOTE:** If you need additional space, please make a photocopy of this form and attach to the original.

## SECTION C: AUTHORIZATION

I hereby authorize the use and disclosure of my protected health information as described below, and understand and acknowledge the following:

**Right To Revoke:** I may revoke this authorization at any time by giving written notice of my revocation to the Plan's Privacy Officer. My revocation of this authorization will not affect any action taken in reliance on this authorization before receipt of my written notice of revocation.

**No Conditions:** The Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

**Effect Of Granting This Authorization:** The protected health information described in this authorization may be disclosed to and/or received by persons that are not subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

## SECTION D: EXPIRATION AND REVOCATION

**Expiration:** This authorization will automatically expire upon termination of coverage under the Plan for the individual named in Section A or upon written receipt of revocation by the individual named in Section A.

## SIGNATURE AND CONSENT OF INDIVIDUAL

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information as described in this form.

This authorization does **NOT** give the personal representative(s) named in Section B control over the individual's healthcare, nor does it grant the personal representative(s) named in Section B decision-making power over any aspect of the individual's healthcare. This authorization only gives the personal representative(s) named in Section B the right to receive disclosures of protected health information for the individual named in Section A of this form.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

If this authorization is signed by a Personal Representative on behalf of the individual, please complete the following:

***(An adult child (18 years or older) must sign their own authorization form.)***

**Personal Representative** *(please print):* \_\_\_\_\_

**Relationship to Individual:** \_\_\_\_\_

**Describe Basis for Authority** *(attach any appropriate documentation):* \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**