Population Health Services

## Authorized Representative Form

Please submit this form to WellSpan Population Health Services, Customer Service Department: P.O. Box 2347, York, PA 17402 • (717) 851-6800 or (800) 842-1768 or fax to (717) 755-7190 or email us at pophealthbenefits@wellspan.org.

**This form provides permission for your Group Health Plan to discuss or give out your personal health information to a person who is your "Authorized Representative" according to the Health Insurance Portability and Accountability Act (HIPAA). Your approval on this form limits the use of your information for that purpose only.**

### A. MEMBER INFORMATION (Please Print Clearly or Type)

| | |
|---|---|
| Subscriber (employee) name: | Telephone number: |
| Subscriber's employer: | |
| Member's name (if requester not the subscriber): | Member's date of birth: / / |
| Identification #: | Member's Social Security number – last 4 - |

***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 want help with your health care and treatment decisions, please contact an attorney for assistance***

### B. DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE RELEASED

Description of information to be released:

☐ All information including eligibility, claims, and medical management.

☐ Specific (please list):

**Special Records:** Protected Health Information to be released **will not include** records of substance and alcohol abuse program treatment, mental health treatment, confidential HIV-related information, or sexual abuse/assault counseling records **unless the specific boxes below are checked**. Checking the boxes is not a representation that such information exists.

☐ Include substance and alcohol treatment records

☐ Include mental health records

☐ Include confidential HIV and AIDs related records

☐ Include sexual abuse/assault counseling records

Entity authorized to release information: **WellSpan Population Health Services**

### C. AUTHORIZED RERESENTATIVE INFORMATION (Parent, Spouse, Doctor, Facility or other, Authorized Representative)

| | |
|---|---|
| Name: | Telephone Number: |
| Address: | |
| Relationship to Member: | |

**Limitation on Disclosure:** I understand that I have the right to limit the information that my Plan releases under this authorization. For example, I may limit my, or my minor child's Authorized Representative's access to information about a particular healthcare provider, diagnosis, or an appealed claim. Any such limitations must be described below. I understand that by leaving this section blank, I am creating no limitations on disclosure, other than that described in Section B above.

_____

_____

## D. EXPIRATION AND REVOCATION

This authorization will expire ☐ Date: / / (or) ☐ until revoked in writing.
Unless otherwise specified above, this authorization will expire one (1) year after the date this request was signed.

I understand that I may revoke this authorization at any time by notifying WellSpan Population Health Services in writing at:
WellSpan Population Health Services, Attn: Customer Service, P.O. Box 2347, York, PA 17402. I understand that revocation will not have any effect on actions WellSpan Population Health Services took before they received the revocation.

## E. AUTHORIZATION INFORMATION AND SIGNATURE

I understand that my Authorized Representative is authorized to file an appeal on my, or my minor child's behalf which will exhaust my right to file an appeal.

This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.

I understand that if the individual or organization to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations and my Authorized Representative may further disclose my personal health information without my authorization.

Signature of member or parent/legal guardian:_____

Date:_____

Printed name of member or parent/legal guardian_____

Relationship to the member:_____

**You are entitled to a copy of this authorization form after you sign it.**