HIPAA Authorization Form to Designate an Authorized Representative

Please complete this form to Designate an Authorized Representative to act on your behalf for your claim, pre-authorization, appeal, complaint or request. By signing this form and designating this authorized representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information and receive all communication about your plan. This person may see your personal medical information. You can revoke this authorization at any time.

Member Information

Member Name (Please Print):

Member ID Number:

Member's Street Address:

City: State: Zip Code:

Designated Authorized Representative Information

Designated Authorized Representative Name:

Relationship to Member:

Designated Authorized Representative's Street Address:

City: State: Zip Code:

Health Information to be disclosed *(Check all that apply)*

- ☐ Claim (claim number):_____
- ☐ Pre-Authorization (reference number):_____
- ☐ Appeal (reference number):_____
- ☐ Complaint (reference number):_____
- ☐ All medical and health plan information/No restrictions
- ☐ Other (please specify):_____

This authorization is effective until (check one):

- ☐ Date or event:_____
- ☐ All past, present, and future periods

I understand and agree that:

- This authorization is voluntary.
- My health information may be disclosed to my authorized representative and may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance use disorders, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I authorize Harbor Health Insurance Company and its affiliates to disclose my health information to the individual named above for the purpose of assisting with benefit coordination, claims, appeals, or other plan-related matters.
- I may not be denied treatment, payment for health care services, enrollment, or eligibility for health care benefits if I do not sign this form.
- I may revoke this authorization at any time by notifying Harbor Health in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of member or approved party | Name (Print) | Date (mm/dd/yyyy)

If person signing this authorization is not the member, describe relationship to the member (i.e., parent, legal representative)

Harbor Health