Authorized Representative Form

Section A: Psychotherapy notes:

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information (PHI).

Section B: Individual authorizing use and/or disclosure:

Name: _____

Address: _____

Telephone: _____ Member Identification Number: _____

Section C: The use and/or disclosure being authorized:

Specific Protected Health Information to Be Used and/or Disclosed:

_____

_____

Entities or Persons Authorized to Use or Disclose: {Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above} PLEASE PRINT.

_____ _____

_____ _____

Entities or Persons Authorized to Receive: {Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above} PLEASE PRINT.

_____ _____

_____ _____

Purpose of this Authorization:

☐ At request of individual.

☐ For the following purposes:

_____

_____

Effect of Granting this Authorization: The protected health information used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Section D: Expiration and revocation:

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to you. I understand that I may call the Client Services number on my Identification Card to request that a Revocation form be mailed to me. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Individual's Signature:

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

Print Name: _____

Signature: _____ Date: _____

If this authorization is signed by a personal representative (i.e., with LEGAL AUTHORITY to act on behalf of the individual), complete the following:

Personal Representative's Name: _____

Signature: _____ Date: _____

Relationship to Individual: _____

INSTRUCTIONS FOR COMPLETION OF THE HEALTHLINK GENERAL ENROLLEE AUTHORIZATION FORM

Please complete all items of information in this section to include your Full Name and ENROLLEE ID Number exactly as they appear on your Identification Card, your current address and a telephone number where you may be contacted.

Section A: Psychotherapy notes

If Psychotherapy notes is checked, authorization will be VOID for any and all other uses and disclosures.

Section B: Individual authorizing use and/or disclosure

Please complete all items of information in this section to include your Full Name and Member ID number (exactly as they appear on your identification card), your current address, and a telephone number where you may be contacted.

Section C: The use and/or disclosure being authorized

- **Specific Protected Health Information (PHI) to be Used and/or Disclosed:** Enter the specific protected health information that you want used or disclosed. For example, if you want claims status information to be disclosed to a third party acting on your behalf, you may to enter the following narrative in these spaces: "All information concerning the status of pending claims, billing status or any other information needed to respond to a normal customer service inquiry on my behalf".

- **Entities or Persons Authorized to Use or Disclose:** If you are authorizing HealthLink to disclose this information to another third party acting on your behalf, please enter the following in these spaces: ***"HealthLink"***

  Entities or Persons Authorized to Receive: **Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI and act on your behalf. For example, if you are authorizing your spouse or any other individual to act on your behalf, enter his/her name in these spaces.**

- **Purpose of this Authorization:** There are two blocks in this section. Please complete **only one** of these blocks per the following instructions:

  If you check the "At request of individual" block, you are authorizing the person(s) or organization(s) you specified in the previous entry to receive your PHI and act on your behalf for any purpose permitted by the HIPAA Privacy Rule. Checking this block is recommended because it will give your authorized representative and the HealthLink Customer Care Associates maximum flexibility to work together to respond to and resolve your service questions and needs. **If you check this block, no further entries are required in this section**.

  If you check the "For the following purposes:" block, you must enter a specific purpose for the authorization in the spaces provided. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information and act on your behalf to handle a specific claims issue, you would enter ***"To about claim status information applicable to claim for services of XX/XX/XX"*** or something similar in that block

  If you use this block, you need to know that HealthLink will only be able to discuss information pertaining to the purposes you specified with your authorized representative and nothing else.

Section D: Expiration and Revocation

- **Expiration:** There are two blocks in this section. Please complete **only one** of these blocks per the following instructions:

  If you want the authorization to expire on a certain date, please check the first block and enter that date in month, day and year order as specified ***(Example: 12/31/2004)***. **If you enter a date in this space, no further entries are required in this section.**

  If you want the authorization to expire when a future event occurs, please enter that event in the spaces provided for this block.

- **Right to Revoke:** Provides instructions to revoke authorization.

Individual's Signature

Please print your name in the first space and then sign and date it in the spaces provided. If your legal representative or guardian signs the form on your behalf, your legal representative or guardian must print his/her name, sign and date the form and indicate his/her relationship to you in the spaces provided.

Return the form to the following address:

HealthLink
Attention: Eligibility
1831 Chestnut Street
St. Louis, MO 63103

Please keep a copy of this authorization form for your records.