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PERSONAL REPRESENTATIVE FORM

Note: This form is used to confirm an Individual's permission that the Plan may use or disclose their Protected Health Information to a particular person who acts as their Personal Representative. Use of their information is strictly limited to that purpose described above.

Section A: Individual Information

By signing this form in Section E below, I understand and agree that the Plan and its business associates NECA / IBEW Family Medical Care Plan may release my Protected Health Information as defined in Section B below to my Personal Representative(s) named in Section C below.

Individual's Name: ____________________

Address: ____________________

Telephone Number: ____________________ Individual ID Number: ____________________

E-mail Address: ____________________ Social Security Number: ____________________

Please Note: This authorization does not provide your "Personal 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

- Protected Health Information from (insert date) _______________ to (insert date) _______________, including but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information.
- My Protected Health Information to be released to my Personal Representative(s) shall include information relating to (check all that apply):

  ☐ Mental Health Treatment, excluding any psychotherapy notes
  ☐ Alcohol and Drug Abuse
  ☐ Confidential HIV-related Information

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:
I understand that your general policy is not to disclose my Protected 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 use and disclose my Protected 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 Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my Protected Health Information may no longer be protected by those privacy laws and my Personal Representative may further disclose my Protected Health Information without my authorization. I acknowledge that my authorization is voluntary.

Personal Representative #1:

Name: ______________________ **Phone Number**: ( ) ____________

Address: ____

Relationship to You: ______________ **Provide a Password:** ______________

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Personal 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.

Limitations on Disclosure: ____

Personal Representative #2:

Name: ______________________ **Phone Number**: ( ) ____________

Address: ____

Relationship to You: ______________ **Provide a Password:** ______________

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Personal 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.

Limitations on Disclosure: ____

Section D: Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire (choose one & complete)
☐ 30 Days ☐ 90 Days ☐ One year ☐ Other ________________________, from the execution date below.

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 Personal Representative, I must revoke this authorization **in writing** by giving written notice of my decision to the 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.

NECA/IBEW Family Medical Care Plan
Administrative Office
410 Chickamauga Ave Suite 301
Rossville, GA 30741 Telephone: (706) 841-7000 Toll Free: (877) 937-9602

Section E: Signature / Authorization

I have had the opportunity to read and consider the content of this Personal Representative Form. I confirm that this authorization is consistent with my request of the 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:** ______________

Please return the signed Authorization Form to the Administrative Office listed in Section D.