



Phone (706) 841-7000 • Toll Free (877) 937-9602  
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## AUTHORIZED REPRESENTATIVE FORM

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 Authorized Representative. Use of their information is strictly limited to the purpose described below. We will not condition benefit payments, enrollment, or eligibility for benefits on the execution of this form.

**THE COMPLETED FORM SHOULD BE RETURNED BY EMAIL TO FMCP\_CUSTOMER\_SERVICE@NIFMCP.COM, BY FAX TO (706) 841-7020, OR BY MAIL TO THE ADDRESS LISTED IN SECTION D ON PAGE 2 OF THIS FORM.**

### 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 below in Section B, to my Authorized Representative(s) named below in Section C.

Individual's Name: \_\_\_\_\_

SSN: \_\_\_\_\_ ID Number: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a healthcare partner/proxy or a clinical personal healthcare representative, or if you want to set up a living will, please discuss those options with your primary care physician or your attorney.**

### SECTION B: TYPE OF INFORMATION

Protected Health Information from **date** \_\_\_\_\_ to **date** \_\_\_\_\_, including but not limited to, identification of healthcare providers, diagnoses, procedures, and demographic information.

My Protected Health Information to be released to my Authorized Representative(s) shall include information relating to (check all that apply):

- Mental health treatment (excluding any psychotherapy notes)
- Alcohol/drug use
- Confidential HIV-related Information

### SECTION C: AUTHORIZED USE AND/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 Authorized Representative is not a healthcare 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 Authorized Representative may further disclose my Protected Health Information without my authorization. I acknowledge that my authorization is voluntary.

## AUTHORIZED REPRESENTATIVE #1

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular healthcare 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: \_\_\_\_\_

## AUTHORIZED REPRESENTATIVE #2

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular healthcare 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 Authorized Representative(s) will automatically expire:

**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 Authorized Representative(s), 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  
Benefit Office  
410 Chickamauga Avenue, Suite 301  
Rossville, GA 30741

## SECTION E: SIGNATURE/AUTHORIZATION

I have had the opportunity to read and consider the content of this Authorized 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** \_\_\_\_\_