First MEDICAL HEALTH PLAN, INC.

Authorized Representative under HIPAA Designation Form

An Authorized Representative is a person named by a beneficiary/subscriber to consent to receive Protected Health Information (PHI). By signing this form, I am authorizing First Medical Health Plan, Inc. (First Medical) to discuss and/or disclose my Protected Health Information, including claims data to the person designated as Authorized Representatives. This authorization is not a power of attorney and does not allow the Authorized Representative to make decisions about my treatment or health care.

I. Beneficiary/Subscriber Information: (Please use print letter)

Name:	Initial:	Last Name:
Date of Birth:	Plan Identification Number/Contract number:	
Mailing Address:		
Home Phone Number:	Mobile Phone Number:	

Email Address: _____

☐ I authorize First Medical to send information to my email in a secure manner (Encrypted).

II. Request Type

☐ **New Application-** Assign a new Authorized Representative to act on my behalf or on behalf of my dependent.
☐ **Update an Existing Application-** Modify the appointment of an Authorized Representative.
☐ **Revoke Appointment of Authorized Representative-** Request an Authorized Representative termination.
Please indicate the termination effective date: _____

III. Information of the person or organization appointed as an Authorized Representative

Name:	Driver's License or S.S. last four digits:	
Mailing Address:		
Home Phone Number:	Mobile Phone Number:	Fax Number:
Relationship with the Beneficiary/Subscriber:		

Name:	Driver's License or S.S. last four digits:	
Mailing Address:		
Home Phone Number:	Mobile Phone Number:	Fax Number:
Relationship with the Beneficiary/Subscriber:		

IV. Appointment Limitations:

You have the right to limit the type of information that can be provided to the Authorized Representative(s) named in section III of this formulary. I also understand that by leaving this section in blank, I'm not creating any limitation on the information that may be disclosed to the Authorized Representative(s).
Authorization Limitations:

☐ Claims and Payments	☐ Eligibility and Enrollment	☐ Referrals and Prior-Authorizations
☐ Medical Record	☐ Debts and Billings	☐ Sexually Transmitted Diseases
☐ HIV/AIDS	☐ Alcohol/Controlled Substances	☐ Abortions/Family Planning
☐ Appeals	☐ Others:	

V. Expiration

This appointment is effective from the date of appointment, until the term of duration that you specify:

☐ Six (6) months	☐ One (1) year	☐ To ____/____/_____

VI. Your Rights:

I understand that:

- This appointment is based on my need and First Medical does not impose it as a condition for treatment, payment, enrollment, or eligibility benefit.
- I can revoke this appointment at any time by giving First Medical a written notice at least five (5) business days at the address listed below. If I revoke this appointment, this will not affect any action that First Medical has taken before receiving the written notification.
- Once my Protected Health Information is disclosed to the person or organization specified in section III of this form, the information in their possession may not be protected by the Portability and Accountability Insurance Act (HIPAA) or any other federal or local law that protect the privacy of health information.
- First Medical will not treat someone as your Authorized Representative if we reasonably believe that: (1) You may be subject to domestic violence, abuse or neglect by this Authorized Representative; (2) By treating this person as your Authorized Representative may put your life in danger; or (3) In the exercise of professional judgment First Medical decides that it is not in your best interest to treat the person as your Authorized Representative.
- This request will expire on the date specified in section V of this form or at the time of revocation.
- I can request a copy of this signed form.

VII. Certification

I, _____, have had the opportunity to read and understand the contents of this form. I freely and voluntarily relieve First Medical from all liability that may arise from the appointment of the Representative(s) Authorized. I understand that by signing this document I authorize First Medical to allow my Authorized Representative to act on my behalf as described above.

Beneficiary/Subscriber's Signature: _____ Date: _____

If you are a Beneficiary/Subscriber's Legal Representative, you must:

1. Indicate your full name: _____
2. Describe your authority to act on behalf of Beneficiary/Subscriber (for example: power of attorney, court order, etc.) _____
3. Provide a copy of the legal document that names you as Legal Representative. A representation document from Social Security is not admissible for purposes of this form (please request assistance from a Customer Service Representative). _____

Incomplete forms will not be processed. All fields are required, unless otherwise specified. Please complete, sign and send this form to:

First Medical Health Plan, Inc.
Privacy Unit
PO Box 191580
San Juan PR 00919-1580

If you have questions about this form, you may contact First Medical at 787-474-3999, ext. 2108.