APWU Health Plan
Designation of Personal Representative

With this form, you may designate a personal representative to act on your behalf in making health care payment related decisions through APWU Health Plan. The individual(s) you name as your personal representative(s) can be a family member, friend, attorney or unrelated party and will have access to your protected health information (PHI), including diagnoses, medical procedures, medications, treating providers, and information such as your date of birth and address. Before we can release this information to your personal representative, you must complete, sign and date, and submit this form to APWUHP. This designation will become effective once it has been entered into our systems, typically within 15 calendar days of receipt.

Please print neatly to ensure accurate processing and to avoid delays in service.

1. Member Information:

Member's ID #: _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: ____ / ____ / ____

Member's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ____ - ____ - ____ Work Phone: _____ - _____ - _____

Policy Holder's Name: _____

Policy Holder's ID#: _____

2. At my request, I authorize my protected health information to be disclosed to:

1. First Name: _____ MI: _____ Last Name: _____

   Relationship to Member: _____

2. First Name: _____ MI: _____ Last Name: _____

   Relationship to Member: _____

3. First Name: _____ MI: _____ Last Name: _____

   Relationship to Member: _____

3. I authorize the following disclosures of my protected health information to the individual(s) listed above.

Check all that apply:

- ☐ ALL of My Information
- ☐ Claims and Explanation of Benefits (EOB) Information
- ☐ Enrollment and Benefits Information
- ☐ Premium Payment Information
- ☐ Any Documents Related to an Appeal
- ☐ Mental Health and Substance Abuse Information

To further limit the information being shared, please be as specific as possible when selecting the options below:

☐ All services for a specific date (provide dates of service):

From: _____ To: _____

☐ All services from a specific health care provider (list provider's name):

_____

☐ Other (please list specific PHI):

_____

The information may be released for the following reason(s)*

_____

_____

_____

* You may enter 'at my request.'

4. Expiration:

I would like this designation to expire

☐ on ___ / ___ / ___ (Check this option if you wish to specify an expiration date for this designation)

☐ after a specific event has occurred (e.g. after knee surgery or at end of pregnancy):

_____

_____

Unless an option above has been selected, this designation will expire two (2) years after your coverage at the APWU Health Plan ends.

5. Right to Revoke (Cancel):

I understand that I may revoke this designation at any time by sending a letter to the APWU Health Plan. Revoking this designation will not affect any action that the APWU Health Plan took prior to receiving the written notice of revocation. The revocation should be sent to the APWUHP, Privacy Specialist, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061.

Please refer to the Notice of Privacy Practices, available at **www.APWUHP.com**, for information pertaining to your opportunity to revoke an authorization, as well as the exceptions to this right. Also in the Notice of Privacy Practices is an explanation of all other available rights under the Privacy Rule.

6. Signature:

I, _____, hereby authorize the use and/or disclosure of my protected health
(PLEASE PRINT NAME)
information as described above.

I understand that:

1. this designation is voluntary and being made at my request;
2. the released information may no longer be protected by federal privacy regulations once it has been released to the individual(s) listed herein;
3. this designation will not be used for medical underwriting; therefore, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this designation.

I have had the full opportunity to read and consider the contents of this designation, and I confirm that the information is consistent with my direction to the Health Plan. I understand that by signing this form, I am giving my authorization to my Health Plan to use and/or disclose the protected health information specified in the contents of this designation to the individual(s) named.

Signature: _____ **Date:** _____

7. Please mail this Designation of Personal Representative to:

APWU Health Plan
Privacy Specialist
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061
1-800-222-2798

Please keep a copy of this designation for your records.
We will provide you with a signed copy of this designation at your request.

Any mental health or substance abuse information disclosed by APWU Health Plan may be protected by federal and/or state laws. If these records are protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from further disclosing the information unless the subject of the information has given his/her written consent, or as otherwise permitted by 42 CFR Part 2. A general authorization for release of protected health information or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information for the intent of criminal investigation or prosecution of any alcohol or drug abuse patient.