

## HIPAA AUTHORIZED REPRESENTATIVE DESIGNATION FORM

An Authorized Representative is a person designated by a beneficiary/subscriber to consent that Protected Health Information (PHI) may be received on his/her behalf. By signing this consent form, I am authorizing First Medical Health Plan, Inc., (First Medical) to discuss and/or divulge my Protected Health Information, including claims information, to persons designated as Authorized Representatives. This authorization is not a power of law and does not allow the Authorized Representative to make treatment or health care decisions.

I. Beneficiary/Subscriber Information: (Please write in print letter)			
Name:	Initial:	Last Name:	
Date of Birth:		Plan Identification Number/Contract Number:	
Postal Address:			
Residential Phone:		Cell Phone:	
Email: _____			
<input type="checkbox"/> I authorize First Medical to send information to my email in a secure (Encrypted) manner.			
II. Type of Application			
<input type="checkbox"/> <b>New Application:</b> Assign an Authorized Representative to act on behalf of myself or my dependent.			
<input type="checkbox"/> <b>Update Existing Application:</b> Modify designation of an Authorized Representative.			
<input type="checkbox"/> <b>Revoke Authorized Representative Appointment:</b> Request termination of an Authorized Representative.			
Please indicate effective date of termination:			
III. Information of the person or organization designated as an Authorized Representative			
Name:			
Postal Address:			
Residential Phone:	Cell Phone:	Fax Number:	Driver's License Number or last four digits of SS.:
Relationship with the Beneficiary/Subscriber:			
Name:			
Postal Address:			
Residential Phone:	Cell Phone:	Fax Number:	Driver's License Number or last four digits of SS.:
Relationship with the Beneficiary/Subscriber:			
IV. Limitations of appointment:			
You have the right to limit the type of information that may be provided to the Authorized Representative(s) named in box III of this form. I understand that, by leaving this section in blank, I am not limiting the information that may be disclosed to the Authorized Representative(s).			
Authorization Limitations:			
<input type="checkbox"/> Claims and Payments	<input type="checkbox"/> Eligibility and Affiliation	<input type="checkbox"/> Referrals and Pre-authorizations	
<input type="checkbox"/> Medical Record	<input type="checkbox"/> Debts and Billing	<input type="checkbox"/> Sexually Transmitted Diseases	
<input type="checkbox"/> VHI/AIDS	<input type="checkbox"/> Alcohol/Controlled Substances	<input type="checkbox"/> Abortions/Family Planning	
<input type="checkbox"/> Appeals	<input type="checkbox"/> Other:		

## V. Validity

This nomination is effective as of the date of designation, until the term of duration that you specify:

Six (6) months

One (1) year

Other Term / /

## VI. Your Rights

I understand that:

- This nomination is based on my necessity. First Medical does not impose or make it a condition of receiving treatment, payment, membership enrollment, or eligibility for benefits.
- I may revoke this nomination at any time by giving written notice to First Medical at least five (5) business days in advance. If I revoke this nomination, it will not affect any action First Medical has taken prior to receiving written notice.
- Once my Protected Health Information has been given to the person or organization specified in box III of this form, the information in the person's possession may not be protected by the regulations of the Health Insurance Portability and Accountability Act (HIPAA) or any other federal or local law that protects the privacy of health information.
- First Medical will not be treating someone as your Authorized Representative if we have reason to believe that: (1) You may be subject to domestic violence, abuse, or neglect by your Authorized Representative; (2) Treating the person as your Authorized Representative may place you in danger; or (3) In the exercise of First Medical 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 box V of this form or upon revocation.
- I may request a copy of this signed form.

## VII. Certification

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

Signature of the Beneficiary/Subscriber: \_\_\_\_\_

If you are a Legal Representative of the Beneficiary/Subscriber, you must:

1. Indicate your full name: \_\_\_\_\_
2. Describe your authority to act for the Beneficiary/Subscriber (e.g., power of attorney, court order, etc.)  
\_\_\_\_\_
3. Provide a copy of the legal document that designates you as Representante Legal. A Social Security document of representation is not acceptable for the purpose of this form (if you need assistance or have any request, please, refer to our Customer Service Representatives).

Incomplete forms will not be processed. All fields are required to be completed in full, 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 any questions about this form, please contact First Medical at: (787) 474-3999, ext. 2108.