

Please read the following instructions for completing the authorization carefully. If you have any questions regarding completing the form, please call Andee Creger, Compliance Dept at 605-399-7363.

Individual Authorizing Disclosure: Complete name, address, and at least one of the following: Group Health Plan ID number or SSN.

Personal Representative Appointment: Check the boxes that apply. For minor plan dependents' healthcare information to be released, check box two and identify the plan dependents by name. In addition, explain how you would like the Authorized Representative to act on your behalf. **Example:** If you want your Authorized Representative to act on your behalf only for a specific time period or relating to a specific injury or treatment for a specific injury, check box one or four. If there are no restrictions, please state "Any and all healthcare information relating to _____" (identify plan member by name).

Expiration and Revocation: This section is Optional. This appointment will expire upon termination of health plan coverage, or upon settlement of claims incurred while covered. If you want expiration to occur on a specific date or occurrence, please enter the date or occurrence here.

Individual's Signature: Print your name on the blank line and sign and date the form.

Acceptance of Appointment: The person you are designating to be the Authorized Representative needs to sign and date the form accepting the appointment. The Authorized Representative needs to print their name, address, and phone number.

CONFIDENTIAL



Personal Representative Appointment and Authorization to Release Protected Health Information

This form is used to authorize First Administrators, Inc. to disclose protected health information at the request of the individual.

Individual Authorizing Disclosure

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

Personal Representative Appointment

I appoint the individual named below to act on my behalf as my Authorized Personal Representative with First Administrators, Inc., in connection with:

- My inquiries and claims for health care benefits with the dates of services: (specify dates)

- All inquiries and claims for health care benefits for the following minor dependent(s): (specify names)

- All claims or inquiries for health care benefits on and after the effective date of this appointment.
- My appeal of denied claim(s) with the date(s) of service: (specify dates) _____

This appointment of Authorized Personal Representative is effective upon First Administrators, Inc.'s receipt of a fully completed and signed original or exact copy of this form at the address stated below.

Use or Disclosure Being Authorized

Effect of Granting this Authorization: I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

Prohibition or Redisclosure: This form does not authorize the disclosure of medical information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (SDCL 27A-12) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

No Conditions: This authorization is voluntary. First Administrators, Inc. will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.



First Administrators Inc

Expiration and Revocation

Expiration: This authorization will expire upon termination of my health plan coverage, or upon settlement of claims incurred while covered, unless revoked or an earlier date or event is entered below:

On _____/_____/_____ (Date)

On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation of First Administrators, Inc. at the address stated below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Individual's Signature

Specific Authorization for Release of Mental Health, Substance Abuse Treatment of Aids-Related Information:

I authorize the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, and all claims information to the individual named below as long as this appointment of Authorized Representative is in effect. I understand that I may inspect the mental health information disclosed.

I, _____, have had full opportunity to read and consider the contents of this personal representative appointment and authorization, and I understand that, by signing this form, I am confirming my authorization of the disclosure of my protected health information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

Signature: _____ Date: _____

Individual's Signature (of Legal Guardian of applicable)

Print Name of Legal Guardian if applicable

If a legal guardian signs for an individual 18 years or older, a copy of the guardian appointment document must be submitted with this form.

Acceptance of Appointment (To be completed by Authorized Representative)

I accept the appointment as Authorized Personal Representative as stated above.

Signature: _____ Date: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ E-mail: _____

Retain a Copy for Your Records - Send Completed and Signed Form To:

First Administrators, Inc.
Compliance Dept.
512 Main St., Suite 200
PO Box 8150
Rapid City, SD 57709

If you have questions about how to complete this form, please call (605) 399-7300.