American Specialty Health

AUTHORIZED PERSONAL REPRESENTATIVE | CALIFORNIA MEMBERS

Please read this Authorized Personal Representative form carefully and fill it out completely. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

MEMBER INFORMATION

Member Name _____ Date of Birth _____

Health Plan Name _____ ID Number _____

Street Address _____

City _____ State _____ ZIP _____

Telephone _____

PERSONAL REPRESENTATIVE INFORMATION

I authorize the following individual to receive the protected health information (PHI) and exercise any related privacy rights regarding the member listed above for the purpose noted below:

Name _____

Street Address _____

City _____ State _____ ZIP _____

Telephone _____ Fax _____

PURPOSE

The purpose of this authorization is limited to the following (please describe why this information is being disclosed; attach additional pages as necessary): _____

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AUTHORIZED PERSONAL REPRESENTATIVE | CALIFORNIA MEMBERS [CONTINUED]

INFORMATION TO BE DISCLOSED

This authorization is limited to the following PHI (choose one):

- ☐ All records including, but not limited to, all chart entries, diagnoses, test results, and reports.
- ☐ Only records relating to the following dates(s) of service: .....
- ☐ Only records relating to the following diagnosis/symptoms: .....
- ☐ Other (please explain): .....

.....

.....

Include: (Indicate by Initialing)

..... **Alcohol/Drug Treatment**

..... **Mental Health Information**

..... **HIV-Related Information**

ACKNOWLEDGEMENT & SIGNATURE

Signing this form means that I understand and agree to the following:

- I understand this Authorization is good for a period of one (1) year from the date I sign it. The Authorization will expire after that time period.
- I understand that I may revoke this Authorization at any time by notifying American Specialty Health (ASH) in writing at: Attn: Privacy Officer, American Specialty Health, 10221 Wateridge Circle, San Diego, CA 92121. If the Authorization is revoked, it will not have any effect on disclosures that were made before my notification revoking this Authorization was received by ASH.
- I understand that the Personal Representative designated above may exercise any and all privacy rights normally extended to the member identified above, including access to PHI about the member.
- I understand that disclosures to the Personal Representative designated above will include application and enrollment information, eligibility information, claims records, claims status and member medical records information including information about chronic diseases, and/or genetic marker information about the identified member.

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AUTHORIZED PERSONAL REPRESENTATIVE | CALIFORNIA MEMBERS [CONTINUED]

ACKNOWLEDGEMENT & SIGNATURE CONTINUED

- This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV-RELATED INFORMATION** only if I place my initials on the appropriate line on this form in the section titled "INFORMATION TO BE DISCLOSED." In the event the health information authorized to be disclosed includes any of these types of information, and I initial the line in "INFORMATION TO BE DISCLOSED", I specifically authorize release of such information to the person (s) indicated in the "PERSONAL REPRESENTATIVE INFORMATION" section.
- I understand that if I am authorizing the release of **HIV-RELATED INFORMATION**, **ALCOHOL** or **DRUG ABUSE** treatment, or **MENTAL HEALTH TREATMENT** information, the recipient may be prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.
- I understand that this Authorization is voluntary. ASH is able to provide treatment or process payment, enrollment, or eligibility for benefits without this authorization. ASH will not deny treatment, payment, enrollment, or eligibility for benefits if I do not sign this authorization, except in the case of: (a) research related treatment; (b) pre-enrollment underwriting or risk determination; or (c) provision of health care solely for the purpose of creating PHI for disclosure to a third party.
- I understand the disclosed PHI may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy law.
- I authorize American Specialty Health Incorporated and any of its parents, subsidiaries, or other affiliates that manage my benefits, to disclose PHI about the member listed above.

I hereby certify that I have read, understand and agree to the terms of this document and designate the individual listed above as the identified member's Personal Representative.

Signature _____ **Date of Signature** _____

Printed Name _____

Relationship to Member: ☐ Self ☐ Other (complete the information below)

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AUTHORIZED PERSONAL REPRESENTATIVE | CALIFORNIA MEMBERS [CONTINUED]

ACKNOWLEDGEMENT & SIGNATURE CONTINUED

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation.

Name .....

Street Address .....

City ..... State ..... ZIP .....

Telephone .....

Description of Representative's Authority to Act/Relationship to Member (choose one):

☐ Member is a minor and I am the member's parent or legal guardian.

☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).

☐ I am the member's agent, as designated in the member's Durable Power of Attorney for Health Care (please attach necessary documentation).

☐ Other (please describe and attach necessary documentation): .....

.....

.....

.....

RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746

Please keep a copy of this form for your records. If you need a copy, you may request one from us.

- Form continues on Pages 5 and 6 -

American Specialty Health

AUTHORIZED PERSONAL REPRESENTATIVE | CALIFORNIA MEMBERS [LANGUAGE ASSISTANCE]

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 800-678-9133. For more help, call the CA Dept. of Insurance at 1-800-927-4357.

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 800-678-9133. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 800-678-9133 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 800-678-9133 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 800-678-9133 . Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 800-678-9133 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 800-678-9133 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 800-678-9133 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات جانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 800-678-9133 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 800-678-9133 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 800-678-9133 . Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 800-678-9133 . Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 800-678-9133 . Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 800-678-9133 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

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