

Designated Representative Authorization Form

Read this information first:

The Designated Representative form is used to identify the person (s) who are permitted to have the same rights you have to access your confidential protected health information. By signing this form, you are allowing Optima Health to release protected health information to the individual (s) named. Your signature also releases Optima Health from any liability of any nature in connection with the release of your protected health information provided that Optima Health follows the terms detailed in this form. Optima Health is not responsible for any use, misuse or secondary release of information by the individual (s) listed below.

Step 1: Complete the demographic information for the member receiving services:

1. _____ 2. ____/____/____
Name Date of Birth
3. _____
Member ID # or SSN #

Step 2: You must attach a copy of a document that proves an established relationship with the person (s) you name. Examples include court documents, Durable Power of Attorney or a Health Care Power of Attorney documents.

Step 3: Designated Representative Information:

4. Designated Representative: _____
Full Name
5. Relationship to Member: _____
6. Address of Designated Representative: _____
7. Phone Number: (____) _____ - _____ (____) _____ - _____
Home Work
8. Authorization Expiration Date: _____

This authorization will expire two (2) years from the date it was signed unless noted on the expiration date listed above. After the expiration of this authorization, a new authorization must be completed in order to be valid. You may cancel this authorization in writing at any time.

9. _____
Member signature Date
10. _____
Parent/Guardian Signature (if required by State law)
11. _____
Witness