

Release of Information / Authorization of Designated Agent

Member's Name: _____

Member ID or Social Security Number: _____ Date of Birth: _____

Consent is Valid for the length of the Member's Health Insurance Policy unless noted otherwise below:

- ___ Days
- 30 Days
- 60 Days
- 90 Days
- 180 Days
- 1 Year

from the date signed by Member below.

I hereby authorize

	Name/Position
	Address
	City, State, Zip Phone #

to act as my designated agent for the specific purpose of (check all that apply):

- Receiving information about my claims history (limits, if any) _____
- Receiving information about my referrals and authorizations (limits, if any) _____
- Receiving information about my plan benefits (limits, if any) _____
- Updating/changing my personal information (limits, if any) _____
- Changing/designating my Primary Care Physician (PCP) _____
- Ordering member materials and/or plan ID cards _____
- Other _____

I, the undersigned, understand that I may revoke in writing this authorization at any time in the manner outlined in the Sentara Healthcare Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that by signing this form I give Optima Health permission to release the specific information designated above to my representative authorized above. Optima Health will not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization. I understand that any disclosure of information made pursuant to this form carries with it the potential for unauthorized re-disclosure and the information may not be protected by confidentiality laws. I understand that my authorized representative or I may receive a copy of this form. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for the period designated above. In no event will this consent be valid for a term longer than the length of the Member's Health Insurance Policy administered by Optima Health.

Member /Parent/ _____
 Guardian (Please Print)

Witness (Required) _____
 (Please Print)

Signature: _____
 Date _____

Signature: _____
 Date _____

If the above named person is under 18 years of age, is not an emancipated minor, and the authorized representative named above is not the Member's parent or guardian, this authorization must be signed by his / her parent or guardian. Proof of guardianship may be required in some cases.