Optima Health
C/O Lason Inc.
P.O. Box 5028
Troy, MI 48007-5028
www.optimahealth.com

Authorization of Designated Agent

Member's Name: _____
Member ID or Social Security Number: _____
Date of Birth: _____

Consent is Valid from the date signed by the member throughout the length of the Member's Health Insurance Policy unless noted otherwise below*:

*Consent is valid until: __/__/____.
mm/dd/yyyy

I hereby authorize: _____
Name
_____
Address
_____
City, State, Zip Phone #

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

- ☐ 1. Receiving information about my medical claims history, referrals and authorizations, and plan benefits and materials (excluding Behavioral Health)
- ☐ 2. Updating/changing my personal information and preferences
- ☐ 3. Changing/designating my Primary Care Physician (PCP)

If the designated agent listed above is an Optima Health member on the same policy, you can authorize the designated agent to access information through Optimahealth.com.
Please list the Optima Health member number of the designated agent: _____.

I, the undersigned, understand that I may revoke in writing or on optimahealth.com 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 grant the access 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 designated agent 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 _____ Witness (Required)_____
Parent/Guardian (Please Print) (Please Print)

Signature: _____ Signature: _____
Date: _____ Date: _____

If the above named person is under 18 years of age, is not an emancipated minor, and the authorized designated agent 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.