AUTHORIZED REPRESENTATIVE FORM

NOTE: This form is used to grant permission by a person insured under a student health insurance plan to the plan administrator, Ascension Benefits & Insurance Solutions, to disclose the insured person's Personal Health Information (PHI) to the individual(s) specifically designated as the Authorized Representative(s) below. Use of the information collected on this form is strictly limited to the purpose described above.

PLEASE NOTE: This form does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative, or if you want to set up a living will, please discuss this with your primary care physician or your attorney.

We affirm that we will not condition benefits payments, enrollment, or eligibility for benefits on the execution of this form.

A. MEMBER INFORMATION

It is the policy of Ascension Benefits & Insurance Solutions not to disclose Personal Health Information (PHI) to parties other than the insured person, except those directly involved in the insured person's care, without written authorization or as permitted or required by law. By signing this form (in Section F), the insured person is agreeing that Ascension Benefits & Insurance Solutions and the claims administrator may release Personal Health Information, as defined in Section B, to the Authorized Representative(s) named in Section C.

INSURED PERSON'S NAME	DATE OF BIRTH (MM/DD/YY) / /	
COLLEGE OR UNIVERSITY WHERE ENROLLED		
PERMANENT U.S. MAILING ADDRESS		APT#/P.O. BOX#
CITY	STATE	ZIP
PHONE NUMBER	STUDENT ID NUMBER	
EMAIL ADDRESS	SOCIAL SECURITY NUMBER	

B. TYPE OF INFORMATION

The type of information that would be disclosed to your Authorized Representative(s) is what is referred to as Personal Health Information (PHI), including but not limited to: Identification of treating health care providers, information regarding claim or payment status, and demographic information. PHI does *not* include any counseling or psychotherapy notes.

C. AUTHORIZED USE AND/OR DISCLOSURE

Authorization:
I authorize Ascension Benefits & Insurance Solutions and the claims administrator to discuss and disclose my Personal Health Information to the person(s) named below. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my Personal Health Information may no longer be protected by those privacy laws and my personal health representative may further disclose my Personal Health Information without my authorization. I attest that my authorization is voluntary.

Authorized Representative #1	
NAME	PHONE NUMBER
ADDRESS	
RELATIONSHIP TO YOU	

Authorized Representative #2	
NAME	PHONE NUMBER
ADDRESS	
RELATIONSHIP TO YOU	

continued →

D. LIMITATIONS ON DISCLOSURE

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure:

E. EXPIRATION AND REVOCATION

This authorization to release information to my Authorized Representative will automatically expire two years following the termination of my enrollment in the student health insurance plan at my college or university.

I understand that I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Section C to remain as my Authorized Representative(s), I must revoke this authorization by giving written notice of my decision to the plan administrator, Ascension Benefits & Insurance Solutions. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released prior to my request to revoke this authorization.

F. SIGNATURE

By signing this form, I agree to an comply with the conditions specified herein. I further state that I have read and considered the content of this Authorized Representative form, and understand that by signing this form, I am authorizing the plan administrator, Ascension Benefits & Insurance Solutions, and the claims administrator to disclose my Personal Health Information to the person(s) named in Section C. I confirm that my authorization is voluntary, and I understand I can revoke it any time by contacting the plan administrator in writing.

SIGNATURE:	DATE:

Please mail the signed Authorized Representative form to:

Privacy Officer
Ascension Benefits & Insurance Solutions
P.O. Box 240042
Los Angeles, CA 90024
USA

Or fax it to:
1-310-394-0142

You are entitled, upon request, to a copy of this authorization form after you sign it.