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[www.HIPIOWA.com](http://www.HIPIOWA.com)

## PERSONAL REPRESENTATIVE FORM

The purpose of this form is to designate a member's Personal Representative(s) for discussion and disclosure of Personal Health Information by the Iowa Comprehensive Health Association (ICHA), and Benefit Management Inc. (BMI), as their plan administrator. This designation is voluntary and in no way affects benefits, claims processing and payment, or eligibility status.

### Member Information

Member Name	Birth Date	Policy #
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### Type of Information

ICHA and BMI may discuss or release Personal Health Information (PHI) to my Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through ICHA, and BMI, the health plan administrator.

### Authorized Use and/or Disclosure

I authorize ICHA and BMI to release PHI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my PHI may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. ICHA and BMI are not responsible should my Personal Representative further disclose my protected PHI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI.

**Disclosure Limitations:** \_\_\_\_\_

### Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that ICHA or BMI has taken, or any information that has already been released based upon prior authorizations.

### Designation of Personal Representative(s)

Name of Authorized Person	Relationship to Member	SS#
Name of Authorized Person	Relationship to Member	SS#
Name of Authorized Person	Relationship to Member	SS#

### Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

\_\_\_\_\_  
**Signature of Member/Legal Representative** **Date**

\_\_\_\_\_  
**Printed Name of Legal Representative** **Description of Legal Representative's Relationship to Member**