Geisinger Health Plan

AUTHORIZED REPRESENTATIVE FORM

Member Name: _____
Address: _____
Address: _____
Date of Birth: _____
Member Phone #: _____
Member ID #: _____

Section One (Representative(s)): I hereby give Geisinger Health Plan ("Health Plan")* permission to disclose my protected health information (PHI), as outlined below, with the following authorized representative(s).**

☐ Name of representative: _____ Address: _____ Phone: _____
Relationship: _____ _____

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Relationship: _____ _____

☐ Name of representative: _____ Address: _____ Phone:_____
Relationship: _____ _____

Section Two (Types of Disclosure): Indicate the PHI that the Health Plan may discuss with your authorized representative(s). *Note: To discuss any sensitive PHI, you need to complete Section Three.* Please select ***one***:

☐ Any and all dates of service ☐ PHI relating to following date(s): _____

☐ Other (please be specific): _____

Purpose of authorization: ■ At my request ☐ Family member assisting with health care ☐ Other _____

Section Three (Sensitive PHI): If you leave this Section blank, the Health Plan will not discuss any sensitive PHI with your Authorized Representative. Please initial if you would like the Health Plan to discuss any of the following sensitive types of PHI:

_____ (initial) My evaluation, diagnosis and/or treatment for ***substance use disorder***.

_____ (initial) My evaluation, diagnosis and/or treatment concerning my **mental health**. *If the member is a minor 14 years of age or older, the minor child **must** initial here:* _____ (initial)

_____ (initial) My diagnosis, claims and/or treatment related to **HIV/AIDS**

Section Four (Methods of Disclosure): Check one or both:

☐ Verbally (We can discuss PHI,with your Representative, on phone calls and face to face)

☐ Written (We may provide copies of premium and explanation of benefits statements to your Representative upon request)

Section Five (Important Information): By signing this Authorization, I acknowledge that I understand:

• Any information disclosed pursuant to this authorization may be subject to re-disclosure, and no longer protected by Federal or State laws and/or regulations, including HIPAA.
• The Health Plan will not condition treatment, payment, enrollment for benefits on the signing of this authorization.
• This Authorized Representative Form can be revoked at any time (except to the extent that the Health Plan has already taken action pursuant it) by submitting a written request to: CST Privacy Designee 25-80, 100 N. Academy Ave. Danville, PA 17822-3229
• This consent will automatically expire one (1) year after I cease to be a member of the Health Plan.

SIGNATURES

Signature *(Insured Individual or Legal Representative):* ***Date:***

Printed Name *(Insured Individual or Legal Representative):*

Legal Relationship *(If not signed by Insured Individual):*

* Geisinger Health Plan includes Geisinger Health Plan, Geisinger Gold, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Co.
You may designate up to three individuals using this form. For each individual, check the box and fill out **all the requested information.

Instructions to Complete the Geisinger Health Plan* Authorized Representative Form

Purpose: Use this form if you want the Health Plan to discuss your PHI with one or more designated individual(s) such as your spouse, child, caregiver, broker, attorney, or other individual.

General: Please review this form and the instructions carefully.

- Incomplete forms will be returned.
- Per HIPAA, a copy of this form must be retained by the member. **Make a copy of your completed form prior to mailing the original**
- Sections One, Two and Four must be filled out completely
- The form must be *signed* and *dated*
- For the Health Plan to disclose any sensitive PHI (substance use disorder, mental health or HIV/AIDs), you must complete Section Three

Section One (Representatives): Please complete this section completely for each representative. We may use the information provided to verify the identity of the Authorized Representative. Note that to discuss your PHI your authorized representative will also need your Name, Date of Birth, and Member ID#.

Section Two (Types of Disclosure): Please select only one option. If you only want the Health Plan to discuss PHI related to certain dates, you must provide the date(s) (for example - all of 2018 or January 2019). You must, also, select a purpose for the authorization. If you select "other" for any section, your description must be clear and understandable. We will return forms that are incomplete, illegible, confusing, or that we are unable to comply with.

Section Three (Sensitive PHI): We cannot discuss any PHI related to treatment for substance use disorder, mental health or HIV/AIDS treatment unless you initial the appropriate section. If you leave this Section blank, we will take precautions to avoid disclosing any PHI related to these conditions (including refusing to provide any information). If this form is being filled out for a minor child age 14 or older, he or she must initial next to the mental health section for us to discuss PHI relating to that condition.

Section Four (Methods of Disclosure): You must select at least one option. If you select "written", we will, upon request, send copies of certain records to the representative at the address you provided. If the request is voluminous or extensive, we reserve the right to request that the member complete a Protected Health Information Access Request Form.

Section Five (Important Information): Please review this Section before signing and dating. It explains when the authorization expires, how to request a revocation, and other important information about this form.

Signature and Date: If the individual signing the form is a guardian, executor of the estate or power of attorney for the member, that person must submit a copy of the appropriate legal document which proves authority to act on behalf of the member. The relationship must also be specified. This documentation must accompany the Authorized Representative Form if it is not already scanned into the member's record.

Mailing Instructions: Mail or fax the completed form to:

CST
Authorized Representative Form
100 N. Academy Ave.
Danville, PA 17822-3229
Fax: 570-214-9357

If you have any questions about this form please call: 1-800-447-4000

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