MEDICAL STAFFCARE

Authorized Representative

Section 1: Appointment of Authorized Representative

I appoint:

Name: _____

Address: _____

Telephone Number: _____

as my authorized representative for the purposes described in Sections 2 and 3 below. I understand this agreement is voluntary and made to confirm my direction.

I understand that my authorized representative may further disclose my information, and it may not be protected by federal or state privacy laws.

Name: _____

Address: _____

Telephone Number: _____ E-mail: _____

Identification Number: _____ Group Number: _____

Section 2: Scope of Authority

I authorize the disclosure of my protected health information to my authorized representative for the following purposes (check only one):

☐ Disclose my claim for claim # _____ only
☐ Disclose all claims related to my diagnosis of _____ only
☐ Disclose all claims for _____ provider only ***(write name of physician or hospital)***
☐ Disclose all claims for _____ date(s) of service ***(write specific date or span of dates)***
☐ Disclose all of my claims regardless of dates of service, provider or diagnosis
☐ Disclose all eligibility information
☐ Disclose all eligibility and claims information regardless of dates of service, provider or diagnosis
☐ Other: _____

Section 3: Options for Disclosures

I authorize the disclosure of my protected health information to my authorized representative by the following means: (check only one):

☐ Disclose my protected health information by telephone only
☐ Disclose my protected health information by sending all original documents by U.S. mail only (*I understand that choosing this option means that all further disclosures will be given to my authorized representative.)
☐ Disclose my protected health information by both telephone and U.S. Mail (*I understand that choosing this option means that all further disclosures will be given to my authorized representative.)

Section 4: Expiration and Revocation

Expiration: This authorized representative appointment will expire (check only one):

☐ on ___/___/___ ☐ on the occurrence of the following event: _____

Revocation: I understand that I may revoke this authorization at any time by giving written notice of my revocation to **Medical StaffCARE, P.O. Box 6702, Columbia, SC 29260-6702**

I understand that revocation of this appointment will not affect any action you took in reliance on this appointment before you received my notice of revocation.

Section 5: Signature

I, _____, have had full opportunity to read and consider the contents of this appointment, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, the means by which my authorized representative shall receive disclosures, the expiration of this appointment and the option of revoking of this appointment.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:_____ Relationship to Individual:_____

Please return the completed form to: Medical StaffCARE, P.O. Box 6702, Columbia, SC 29260-6702

Questions? Call Medical StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.