



Authorized Representative Form

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.

___ 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 for all members listed on this policy.)

___ 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 for all members listed on this policy.)



Planned Administrators, Incorporated

Section 4: Expiration and Revocation

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

___ On ___/___/___

___ On the occurrence of the following event: _____

___ Upon my revocation

Revocation: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

**Planned Administrators, Inc.
P.O. Box 6927
Columbia, SC 29260
Phone Number: (800) 768-4375**

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: _____

Please return the completed form to: **Planned Administrators, Inc.
P.O. Box 6927
Columbia, SC 29260**

Thank you for your cooperation.

Claims Representative