AUTHORIZATION FORM FOR DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) TO DESIGNATED PERSONAL REPRESENTATIVE(S)

I hereby authorize the use or disclosure of protected health information about me by the Company as described below. As used in this authorization, the Company shall mean CHAMP, dba Customized Health And Medicare Plans, 1005 South Jackson Street, Jacksonville, TX 75766.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

Name _____ Relationship _____

Address _____City _____St _____Zip_____

Cellphone _____Work Phone _____ Email _____

Name _____ Relationship _____

Address _____City _____St _____Zip_____

Cellphone _____Work Phone _____ Email _____

Name _____ Relationship _____

Address _____City _____St _____Zip_____

Cellphone _____Work Phone _____ Email _____

I grant to the individual(s) named above access to (**MUST CHECK ONE**):

- ☐ All of my health information – I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse
- ☐ My Health Information relating to a specific treatment or condition.
  Only release information regarding to _____
- ☐ My health information covering the period from:
  From Date: _____ To Date: _____
- ☐ Other _____

I understand that this designation will (**MUST CHECK ONE**):

- ☐ Be effective for my lifetime unless revoked
- ☐ Expire two (2) years from the date the authorization is signed

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

Insured / Client Name_____ Date of Birth _____

Insured / Client Legal Representative Name _____

Insured / Client or Legal Reprentative Signature _____ Date _____