DESIGNATION OF PERSONAL REPRESENTATIVE
For Use and Disclosure of Protected Health Information (PHI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that an individual has the right to have one or more persons act as a representative to make decisions about the uses and sharing of Protected Health Information (PHI). The individual can limit the amount of PHI that the authorized personal representative can utilize, and the individual can also revoke this at any time. (45 C.F.R § 164.502 (g))

DESIGNATION OF PERSONAL REPRESENTATIVE

I, ____,
Patient Name

designate Rollins Advocacy & Consulting, LLC, including its employees and business associates, to act as my authorized personal representative with respect to my appeal of a denial of a surgical treatment.

I authorize: ____
Name of Insurance Company

to release to my personal representative all of my PHI as requested by them, including any and all documents related to my appeal. I understand that this authorization is voluntary. I understand that my health information may be protected by HIPAA and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. I also understand that my health plan may not predicate treatment, payment, enrollment or eligibility for benefits on whether I sign this form.

This authorization will expire one year from the date entered below OR upon the conclusion of my appeal process, whichever comes first. I understand that I may revoke this authorization at any time by notifying my personal representative in writing, but if I do, it will not have any effect on any actions taken before the authorization was revoked.

____ ____

Patient Signature *Patient Date of Birth*

____ ____

Patient Printed Name *Date Signed*

____ ____

Patient Insurer *Patient Insurance ID Number*