Authorized Representative Statement

All fields must be completed for this authorization to be valid.

Name: _____ ID # _____
(Please PRINT)

I do hereby swear that I am the above-stated insured individual or an authorized representative of the above-stated individual. I do hereby appoint the following individual to act as my "representative" with Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Co. (collectively referred to as the "Geisinger Health Plan").

Name of representative: _____

Address: _____

Phone number: _____

Relationship: _____

I hereby authorize Geisinger Health Plan to communicate with my Representative for (check one)

☐ Any and all uses and disclosures for treatment, payment and operations.

☐ Uses and disclosures limited to the following specific types of Protected Health Information: (complete)

_____

_____

_____

I authorize the Geisinger Health Plan to release Protected Health Information and related information about me to my representative. The release may contain information pertaining to the following special authorization. If member is under 18, parent or guardian must sign his or her initial next to the information to be released, if applicable.

_____ (initial) My evaluation, diagnosis and/or treatment for alcoholism and/or drug abuse or dependence may be released to my representative noted above.

_____ (initial) My evaluation, diagnosis and/or treatment concerning my mental health/rehabilitation may be released to my representative set forth above. *Children 14 or older must initial.*

_____ (initial) My diagnosis and/or treatment for HIV/AIDS may be released to my representative set forth above.

_____ (initial) Psychotherapy notes may be released to my representative noted above. (Federal law requires a special authorization to use or disclose psychotherapy notes)

_____ (initial) Records and information relating to birth control for minors may be released to my representative noted above. *Children 14 or older must initial*.

This form will expire 6 months after termination of enrollment with Geisinger Health Plan unless a sooner date is noted here: /__/__

The information used or disclosed may be subject to re-disclosure by my authorized representative and no longer protected by applicable Federal and State laws and/or regulations. I understand that a copy of this authorization may be considered as valid as the original. I understand that the Health Plan may not condition treatment, payment, enrollment or eligibility for benefits on this authorization. I understand that this consent may be canceled in writing at any time except, to the extent that the disclosure has already been made. To cancel this authorization I must submit a written request to: CST at 100 North Academy Avenue, Danville PA 17822-2580. Upon receipt of the cancellation of this authorization, the Health Plan shall cease further release of information immediately.

Signed: _____

Insured Individual Signature *Date*

I,_____hereby accept the above appointment. _____

Signature of Appointed Representative *Date*

If unable to give consent because of physical condition or is a minor, state the reason:

_____

_____

Signed: _____

Signature of Parent or Guardian *Relationship* *Date*

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION

If the information disclosed to you relates to substance abuse treatment, these records' confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The federal regulations restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patients' records.

100 N. Academy Ave., Danville, PA 17822-2580
Tel. 570-271-8760 • 800-447-4000 • Fax 570-214 -9357 • TDD 711