AULTCARE

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

You have the right to appoint a representative, including an attorney, to act on your behalf. This form is used to confirm permission to discuss with or disclose a person's Protected Health Information (PHI) held by the affiliated entities AultCare Corporation, AultCare Health Insuring Corporation (AHIC) which also does business as PrimeTime Health Plan, Aultra Administrative Group (AAG), and AultCare Insurance Company (AIC) which also does business as AultCare HMO, to a particular individual who acts as the person's personal representative. We are not always required to grant such access, but each request will be carefully reviewed and approved if warranted. Use of this information is strictly limited to that purpose.

Name	Date of Birth
Member ID Number	Group Number

I hereby authorize the following person to act as my personal representative as indicated below (must fill out).

Name of Representative	Relationship
Password the personal representative must provide to access PHI about me	
OR ☐ No Password Needed	

I understand I have the right to limit the information released under this authorization. For example, I may limit my personal representative's access to information about a particular issue. Any such limitations must be described below in writing. However, if my authorization is for use/disclosure of substance abuse information, I understand the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. Therefore, I release the affiliated entities AultCare Corporation, AultCare Insurance Company, and Aultra Administrative Group from all liability arising from this disclosure of my health information. **Note: State law mandates that authorizations are limited to 12 months. This form will expire upon 12 months from the date of signature unless an earlier date is noted here.** The following items must be checked to be included in the use and/or disclosure of health information pursuant to this Authorization (by leaving this section blank, I am imposing the following limitations on disclosure).

☐ (a) HIV/AIDS related information and/or records ☐ (b) Mental health information and/or records

☐ (c) Genetic testing information and/or records ☐ (d) Drug/alcohol diagnosis, treatment

Any other limitations described here:

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continued on reverse

I understand this authorization is voluntary and I may revoke this authorization at any time by providing written notice of such revocation to the health plan, except to the extent that action has been taken in reliance on this authorization.

I have had full opportunity to read and consider the content of this form. I understand this authorization is consistent with my request. I understand, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my PHI to the person named as personal representative for the purpose as described above.

Signature _____ Date _____

Form must be signed by member. If form is signed by Power of Attorney or Legal Representative, a copy of documentation of position must be in AultCare's receipt or attached to form. Please designate position held.

Please return the completed form to: ATTN: Privacy Coordinator, PO Box 6029, Canton, OH 44706.