First MEDICAL HEALTH PLAN, INC.

HIPAA AUTHORIZED REPRESENTATIVE DESIGNATION FORM

An Authorized Representative is a person designated by a beneficiary/subscriber to consent that Protected Health Information (PHI) may be received on his/her behalf. By signing this consent form, I am authorizing First Medical Health Plan, Inc., (First Medical) to discuss and/or divulge my Protected Health Information, including claims information, to persons designated as Authorized Representatives. This authorization is not a power of law and does not allow the Authorized Representative to make treatment or health care decisions.

I. Beneficiary/Subscriber Information:		
Name:	Middle Name:	Last Name:
Date of Birth (*Month/Day/Year*):		Plan Identification Number/Contract Number:
Postal Address:		
Primary Phone:		Alternate Phone:
Email: _____ ☐ I authorized First Medical to send information to my email in a secure (*Encrypted*) manner.		

II. Type of Application
☐ **New Application:** Assign an Authorized Representative to act on behalf of myself or my dependent. ☐ **Update Existing Application:** Modify designation of an Authorized Representative. ☐ **Revoke Authorized Representative Appointment:** Request termination of an Authorized Representative. Please indicate the effective date of termination:

III. Information of the person or organization designated as an Authorized Representative		
Name:		
Postal Address:		
Primary Phone:	Alternate Phone:	Driver's License Number or last four digits of SS.:
Relationship with the Beneficiary/Subscriber:		
Name:		
Postal Address:		
Primary Phone:	Alternate Phone:	Driver's License Number or last four digits of SS.:
Relationship with the Beneficiary/Subscriber:		

IV. Limitations of appointment:		
You have the right to limit the type of information that may be provided to the Authorized Representative(s) named in Box III of this form. If you leave this section blank, you acknowledge that you are not placing any limitations on the information that may be disclosed to the Authorized Representative(s). **Authorization Limitations:**		
☐ Claims and Payments	☐ Eligibility and Affiliation	☐ Referrals and Pre-authorizations
☐ Medical Record	☐ Debts and Billing	☐ Sexually Transmitted Diseases
☐ VHI/AIDS	☐ Alcohol/Controlled Substances	☐ Abortions/Family Planning
☐ Complaints and Appeals	☐ Mental Health:	☐ Other:

V. Validity		
This appointment is effective from the date of designation, until the duration you specify:		
☐ One (1) year	☐ Other Term ____/_____	☐ Does not expire

VI. Your Rights

I understand that:

- This appointment is based on my need. First Medical does not require it as a condition for receiving treatment, payment, enrollment, or eligibility for benefits.
- I may revoke this appointment at any time by sending a written notice to First Medical at least five (5) business days in advance. If I revoke this appointment, it will not affect any actions First Medical has taken prior to receiving the written notice.
- Once my Protected Health Information has been disclosed to the person or organization specified in Box III of this form, the information in their possession may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) regulations or any other federal or local law that protects the privacy of health information.
- First Medical will not treat someone as my Authorized Representative if we have reason to believe that (1) I may be subject to domestic violence, abuse, or neglect by the Authorized Representative; (2) Treating the person as my Authorized Representative may put me at risk; or (3) In the exercise of professional judgment, First Medical determines that it is not in my best interest to treat the person as my Authorized Representative.
- This request will expire on the date specified in box V of this form or upon revocation.
- I may request a copy of this signed form.

VII. Certification

I, _____
have had a full opportunity to read and understand the contents of this form. I freely and voluntarily release First Medical from any and all legal liability that may arise from the nomination of the Authorized Representative(s). I understand that by signing this document, I authorize First Medical to allow my Authorized Representative(s) to act on my behalf as described above.

Signature of the Beneficiary/Subscriber: _____ Date: _____

If you are a Legal Representative of the Beneficiary/Subscriber, you must:

1. Indicate your full name: _____
2. Describe your authority to act for the Beneficiary/Subscriber (e.g., power of attorney, court order, or medical certification) _____
3. Provide a copy of the legal document that designates you as Representante Legal. A Social Security document of representation is not acceptable for the purpose of this form (if you need assistance or have any request, please, refer to our Customer Service Representatives).

Signature of the Legal Representative: _____ Date:_____

Incomplete forms will not be processed. All fields are required to be completed in full, unless otherwise specified. Please complete, sign, and send this form to:

First Medical Health Plan, Inc.
Privacy Unit
PO Box 191580
San Juan, PR 00919-1580

If you have any questions about this form, please contact First Medical at (787) 474-3999, extension 2108/2583.

The Customer Service Department offers free language interpreter services and sign language. This includes services in alternate formats such as Braille, large print, and translation to other languages, verbally or written, among others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.

First Medical *cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo*. **First Medical** *complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.*

First Medical *遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人.*