HIPAA - Appoint a representative.

I understand that by voluntarily signing this form, I am authorizing and granting MedImpact Healthcare Systems, Inc., permission to provide the person named below the authority to access my Protected Health Information (PHI) to assist in my treatment and/or payment for that treatment. I understand that the information I authorize to disclose could be shared with other people or entities and will no longer be protected by federal privacy regulations. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this form.

This form is intended for Non-Medicare members. If you are enrolled in Medicare and would like to designate a representative to communicate on your behalf about a claim, prior authorization, grievance, appeal or any other decision affecting your care or the services you receive, complete the form located at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** and mail to MedImpact (Attn: Customer Care), 7835 Freedom Avenue NW, North Canton, OH 44720.

Member Information

Member Name _____ Member ID _____

Address _____

City, State, Zip _____

Phone _____ Email _____

Authorized Individual *(Information will be disclosed to this person)*

Name _____ Relationship to Member _____

Address _____

City, State, Zip _____

Phone _____ Email _____

I grant to the individual named above access to *(Must check one)*

- ☐ All of my PHI – 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
- ☐ Other: please specify limits or specific healthcare incident

_____

_____

I understand that this designation will *(Must check one)*

- ☐ Be effective for the lifetime of the member unless revoked
- ☐ Expire one (1) year from the date executed

I understand that I have the right to revoke this authorization, except to the extent MedImpact has acted in reliance upon it, by sending written notice to: MedImpact Privacy Officer, 7835 Freedom Avenue NW, North Canton, OH 44720.

Member Signature _____ Date _____

Please send completed form to one of the following:
Mail to: MedImpact, Attn: Customer Care, 7835 Freedom Avenue NW, North Canton, OH 44720 **Fax:** 866-250-5178
corp_web_all_form_hipaa representative form_23-7495

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