AUTHORIZED REPRESENTATIVE FORM

This form is used to confirm permission for ATRIO Health Plans and related entities to discuss or disclose your personal information, including your Protected Health Information, to a particular person who acts as your Authorized Representative.

This document is available in alternate formats or for persons with special needs, please call (877) 672-8620 Toll Free, or TTY (800) 735-2900 to request this service.

Please send completed and signed form back to ATRIO:
Fax: (541) 672-8670
Mail: ATRIO Health Plans, 2270 NW Aviation Drive Suite 3, Roseburg, OR 97470

SECTION 1: ATRIO MEMBER INFORMATION

Name (First MI Last):	Birth Date: ___ /___ /_____	Member ID #:	
Address:	City:	State:	Zip Code:
Email address:	Home Phone #:	Cell Phone #:	

SECTION 2: REQUEST TYPE

☐ **New Request:** This is a request to assign a new Authorized Representative(s).

☐ **Replace an Existing Request:** This is to replace a previously approved Authorized Representative.

☐ **Revoke an Existing Request:** This form is to request termination of a previously approved Authorized Representative. Enter an effective date for the termination: ___ /___ /_____

Please Note: Any new request forms will automatically replace any existing requests previously approved.

SECTION 3: EXTENT OF AUTHORIZATION

I authorize ATRIO Health Plans to discuss and disclose my personal information to the Authorized Representative(s) named above for the purpose of assisting with, or facilitating, enrollment, the coordination of services or payment of my health plan benefits. I understand that I have the right to limit the type of information that may be given to the Authorized Representative(s).

Select any items below that you DO NOT WANT DISCLOSED to the Authorized Representative(s). I understand that by leaving this section blank, I am creating no limitation on the information that may be disclosed.

☐ Medical records
☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol / substance abuse treatment
☐ Claims information
☐ Prior authorization information
☐ Enrollment, eligibility, benefit information
☐ Premium dues and payment information
☐ Other (please specify): _____

SECTION 4: AUTHORIZED REPRESENTATIVE(S)

1st Authorized Representative			
Name (First MI Last):	Relationship (if any) to Member:		
Home Phone #:	Cell Phone#:		
Address:	City:	State:	Zip Code:
2nd Authorized Representative			
Name (First MI Last):	Relationship (if any) to Member:		
Home Phone #:	Cell Phone #:		
Address:	City:	State:	Zip Code:

SECTION 5: MEMBER'S SIGNATURE/AUTHORIZATION CONFIRMATION

By signing this form, I understand and agree that ATRIO Health Plans, on behalf of itself and its related entities, may release my personal information as stated above to the Authorized Representative(s) listed on this form. I have had full opportunity to read and understand the contents and requirements of this authorization.

Member's Signature*:_____ **Date:** _____

Unless revoked in writing, this Authorization shall remain in force an effect until it expires <u>two years</u> from the date of signature or until the following date: ___ / ___ / _____

***** If the member cannot sign this form, a legal representative may sign, complete and return this form on behalf of the member. A legal representative is someone who has the legal right to sign for the member. Please attach proof that you are the member's legal representative (e.g. Power of Attorney documentation).

Your Rights to Authorized Use and/or Disclosure

I understand that:

- ATRIO Health Plans general policy is to not disclose my personal information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law.
- This form will not alter the manner in which ATRIO Health Plans processes my benefits, payments, enrollment forms or my eligibility for benefits.
- If my Authorized Representative is <u>not</u> a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my personal information, and my Authorized Representative may further disclose my personal information without my authorization.
- I understand that this authorization <u>does</u> <u>not</u> provide my Authorized Representative with any authority, either implied or direct, over any treatment or direct-care decisions.
- I have the right to revoke or end this authorization at any time and must do so in writing or by submitting a new form with updated information.
- If I revoke this authorization, it will not affect any action ATRIO Health Plans or related entities have taken prior to receiving my written notice to revoke.
- I may request a copy of this signed form.
- If I have questions about this form, I may contact ATRIO Health Plans at (877) 672-8620 Toll Free, or TTY (800) 735-2900.