NATIONAL ASSOCIATION OF LETTERS CARRIERS

HEALTH BENEFIT PLAN

20547 Waverly Court, Ashburn, Virginia 20149 ● (703)729-4677 or 1-888-636-NALC (6252)
Fredric V. Rolando, President ● **Brian E. Hellman,** Director

HIPAA Privacy Rule
Personal Representative Authorization

Member Name _____ Member # _____
(as it appears on the Health Insurance and Pharmacy Identification Card)

Section A -- Purpose

This form allows you (the "Individual") to give the NALC Health Benefit Plan permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care; diagnoses; procedures; and personal information, such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older, or as determined by state law), who expects to have a relative or friend act as a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. **You are not required to name a Personal Representative, but if you do not,** we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, child, friend, congressman, or Union representative. You must provide the information requested in Section C for each person before we can treat that person as your Personal Representative. If you need additional forms, you may copy this form, or call us.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions. Also, we will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form.

Section B — Individual's Information *(Individual appointing a Personal Representative)*

I authorize the NALC Health Benefit Plan to treat the person(s) named in Section C as my Personal Representative(s), subject to the rights and the restrictions, if any, described in Section C.

My Name _____ Date of Birth _____

Daytime Phone (_____) _____ Relationship to Member _____

Section C — Authorized Use and/or Disclosure

I understand that the Plan's privacy practice is to not disclose my personal health information, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, **I authorize you to disclose my protected health information to the person(s) named in Section C** for the purpose of assisting with or facilitating the payment of my health plan benefits. Unless I have stated otherwise in *Restrictions*, I also allow my Personal Representative the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI. I understand that if my Personal Representative is not a health plan, a health care provider, or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal Representative may further disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/ disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in *Restrictions,* in this section.

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Personal Representative #1

Full Name _____ Phone Number (____) _____
(please print)

Relationship to You _____
(such as: spouse, parent, child, HBR, friend)

Restrictions: _____

_____

_____

Personal Representative #2

Full Name _____ Phone Number (____) _____
(please print)

Relationship to You _____
(such as: spouse, parent, child, HBR, friend)

Restrictions: _____

_____

_____

**Attach separate page to list additional Representatives*

Section D — Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire two (2) years after the date my coverage in the NALC Health Benefit Plan ends.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named in Section C to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Official at the address shown below. I understand that my revocation of this authorization will not affect any action that you have taken or information that you have already released, based upon the authorization, before you receive my request to revoke authorization.

Privacy Official
NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

Section E — Signature / Authorization

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that the NALC Health Benefit Plan may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature _____ Date _____

(Signature must be the same as the name listed in Section B – Individual's Information)

Please complete and sign this form, and return it to our Privacy Official, at the address shown in Section D. A pre-addressed envelope is enclosed for your convenience. You are entitled to a copy of this completed form.