

# 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

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## 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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