

Northwestern Health Sciences University Health Plan Personal Representative Designation / Authorization Form

Please provide the information requested in each of the applicable blanks below. *This designation/authorization form will not be valid unless the appropriate blanks are filled in and the form is signed.* If you have any questions, contact the Human Resources Benefits Representative.

I. DESIGNATION / AUTHORIZATION

I, _____ designated the individual(s) named below as my personal representative and authorize a representative of Northwestern Health Sciences University (NWH SU) group health plans (Plans), which include health flexible spending accounts, limited counseling sessions through the Employee Assistance Program, and medical and dental insurance, to release Protected Health Information (PHI) about me to the person(s) listed below:

My Spouse. Please provide the following information

Name: _____

Last four digits of spouse's social security number: _____

Date of birth: _____

My Parent(s). Please provide the following information

Name: _____

Relationship: _____

Last four digits of social security number: _____

Date of birth: _____

Name: _____

Relationship: _____

Last four digits of social security number: _____

Date of birth: _____

A designation/authorization is generally not required to release PHI to parents regarding their minor children.

Other. Please provide the following information

Name: _____

Relationship: _____

Last four digits of social security number: _____

Date of birth: _____

Password that your representative will need to give in order to obtain information:

Purpose(s) for which my PHI may be used or disclosed: Name and describe each purpose in detail. If you do not want to describe the purpose for which your PHI may be used and/or disclosed, you may simply state "at my request".

THE BACK SIDE OF THIS FORM MUST BE COMPLETED

II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

1. I may cancel this authorization at any time prior to its expiration date by notifying the providing organization in writing. I understand that the cancellation with NOT apply to any actions the organization took before it received the cancellation.
2. I may see and copy the information described on this form if I ask for it.
3. I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).
4. The information that is used or disclosed as a result of this authorization may be re-disclosed by the receiving person/organization.
5. This authorization is valid for either:
 - a. One year from the date this Designation/Authorization form is signed; or
 - b. The date I notify NWHSU, in writing, that the relationship specified in Part I of this Designation/Authorization form no longer exists (i.e., my spouse and I divorce); or
 - c. Any other date I notify NWHSU, in writing, that this Designation/Authorization has been revoked.

III. SIGNATURE OF PARTICIPANT OR PERSONAL REPRESENTATIVE

By my signature below, I certify that I have reviewed the above information and have/will receive a signed copy of this designation/authorization form for my records. I also understand that, after reviewing the above information, I have the right to refuse to sign this designation/authorization.

Signature of participant requesting a personal representative

Date

FORM *MUST* BE COMPLETED *BEFORE* IT IS SIGNED.