A special notice to our subscribers from the Comprehensive Health Association of North Dakota

ABOUT YOUR PRIVACY

It is our policy and our obligation under federal and state laws to protect the privacy of our subscriber's information. We need your understanding and cooperation to help ensure compliance with these laws. Before we can disclose information about you to someone acting on your behalf, we need to be sure that we have your permission to do so. The enclosed Authorized Representative Form allows us to use and disclose your health information with designated individuals. We also recommend written authorizations for our subscribers who are between ages 12 and 17.

Although parents and other legal representatives generally have the authority to obtain information about their minor children, there are laws that give minors special protections regarding certain kinds of health information. In these cases, the law requires that we have the written permission of the minor child before we may disclose this information, including to their parents. Without this form, we must do a manual review of a minor's health information to determine what information can be provided to the parents or legal guardian. Because of this manual review, there may be a delay in our response.

If you are a North Dakota resident, this authorization will remain in effect for 18 months past your Plan's termination date. If you are a resident of another state, this authorization will terminate 12 months from the date of signature. For members under age 18, this authorization will terminate as of the member's 18th birthday.

Please contact us at the address and/or phone number printed on the back of your ID card with any questions or changes to the preprinted information on the form.

Lead carrier services provided by Blue Cross Blue Shield of North Dakota

INSTRUCTIONS FOR COMPLETION OF THE AUTHORIZED REPRESENTATIVE FORM

Section A: Purpose of Form
No information needed.

Section B: Subscriber Information
Please complete all items of information in this section to include your full name, address and daytime telephone number where you can be contacted, as well as the Benefit Plan Number exactly as it appears on your Identification Card(s). If the pre-printed information is incorrect, please note changes.

Section C: Authorized Use and/or Disclosure
By completing this form, you are allowing the health plan(s) listed on this form to use and disclose your protected health information.

Authorized Representative: Indicate the complete name, day time phone number, address and relationship to you of the person(s) or organization(s) authorized to receive your health information. *Note: You may list more than one Authorized Representative. If you wish to list more than two Authorized Representatives, please fill out an additional form.*

If you want to limit what information your Authorized Representative can receive, please note the restrictions in the area provided in this section. We will notify you, if we are unable to accommodate your request.

Section D: Type of Information
Strike through any of the bullets listed that you do not want to be available to the Authorized Representative(s) designated on this form.

Section E: Expiration and Revocation
This section explains when this authorization will expire. Please check the box only if you want this authorization to terminate in the event of your death.

You may revoke this authorization at any time by sending a written request to Member Services at the address listed on the back of your ID card.

Section F: Signature/Authorization - *The individual listed in Section B must sign*
You must print your name, sign and date this form in the spaces provided. If your legal representative (power of attorney or legal guardian) signs this form on your behalf, a copy of the power of attorney or other relevant document evidencing the authority to represent you should be included.

AUTHORIZED REPRESENTATIVE FORM

Section A: Purpose of Form

This form is used to document the designation of Authorized Representatives for an individual, including a minor who has the right under applicable law to control whether a parent or guardian may have access to the minor's health information. This form authorizes the release of the individual's health information to the Authorized Representative(s) designated on this form.

Section B: Individual Whose Information will be Released to the Designated Authorized Representative(s) Listed Below (Please type or print clearly. This individual should sign Section F.)

Name: _____ Birth Date_____

Address: _____

City: _____State:_____ Zip: _____

Daytime Phone Number: _____ Benefit Plan Number_____

Section C: Authorized Use and/or Disclosure

By signing this form I am allowing the benefit plan(s) listed below to use and disclose my health information with the Authorized Representative(s) designated on this form. Please strike through any of the following you do not want to use and disclose your health information with your designated Authorized Representative(s):

Health coverage by Blue Cross Blue Shield of North Dakota
Health coverage by Comprehensive Health Association of North Dakota
Dental coverage by the Dental Service Corporation
Vision coverage by North Dakota Vision Services Incorporated

I understand that if my Authorized Representative is not subject to federal or applicable state privacy laws, my health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name: _____ Daytime phone number:_____

Address: _____

Relationship to you:_____

Authorized Representative #2:

Name: _____ Daytime phone number:_____

Address: _____

Relationship to you:_____

If you want to restrict the information that the Authorized Representative may receive, indicate those restrictions below. We may not agree to your restrictions. You will be notified if we are unable to agree.

_____

_____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM
If you have questions, contact us at the number printed on the back of your ID card.

Section D: Type of Information

I understand that by completing this form I am allowing the health plans in Section C to use and disclose my health information with my Authorized Representative(s) designated on this form, including any health information in my records relating to (please strike through any of the following health information you do not want to be available to the Authorized Representative(s) you designate on this form):

- sexually transmitted disease
- acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
- alcohol, drug or other substance abuse
- behavioral or mental health services
- other sensitive medical information that applicable law may protect from use or disclosure without my permission

Completion of this form is entirely voluntary. Your refusal to authorize disclosure of your health information to Authorized Representatives will have no effect on our enrollment of you in our health plans, your eligibility for benefits under our health benefit plans or the amount we pay for the health services you receive. Please note that whether or not you elect to complete this form will have no effect on the ability of a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, to have access to certain of your health information when applicable law allows such access without your written permission.

Section E: Expiration and Revocation

For North Dakota residents, this authorization will remain in effect for 18 months past your Plan(s) termination date. For residents of all other states, this authorization will terminate 12 months from the date of signature below. If you are under 18 years of age, this authorization will terminate as of your 18th birthday.

☐ By checking this box, I am indicating that I wish this authorization to terminate in the event of my death. If this box is not checked, this authorization will remain valid as indicated above.

I understand that I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Section C to remain my Authorized Representative(s), I must revoke this authorization **in writing** by giving written notice of my decision to the benefit plan at the address listed on the back of my ID card. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it. I also understand that my revocation may not be effective in preventing release of certain health information to a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, who applicable law allows to have access to such health information without my written permission.

Section F: Signature / Authorization

I understand this authorization is voluntary. I understand my enrollment in a health plan or eligibility for benefits is not conditioned on receiving this authorization.

I understand that the information described above may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the information, and it may no longer be protected by federal health information privacy laws.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Print Name: _____

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.
Please notify us of any changes to the information provided on this form.
If you have questions, please contact us at the number printed on the back of your ID card.