



Personal or Authorized Representative Authorization Form

Read this information first

The Personal or Authorized Representative form is used to identify the person(s) who are permitted to have the same rights you have to access your confidential protected health information. By signing this form, you are allowing ValueOptions to release protected health information to the individual(s) named. Your signature also releases ValueOptions from any liability of any nature in connection with the release of your protected health information provided that ValueOptions follows the terms detailed in this form. ValueOptions is not responsible for any use, misuse or secondary release of information by the individual(s) listed below.

Step 1: Complete the demographic information for the member receiving services:

- | | |
|-----------------------------------|--|
| 1. _____
Name | 2. ____/____/_____
Date of Birth |
| 3. _____
Address | 4. (____)____-_____
Home Phone Number |
| 5. _____
Name of Policy Holder | 6. ____-____-_____
Policy Holder SS# |

7. _____
Member Signature

_____/_____/_____
Month Day Year

8. _____
Parent/Guardian Signature (if required by State Law)

9. _____
Witness

Step 2: You must attach a copy of a document that proves an established relationship with the person(s) you name. Examples include court documents, Durable Power of Attorney or a Health Care Power of Attorney.

Step 3: Personal or Authorized Representative Information

10. Designated Representative: _____
Full Name

11. Relationship to Member: _____

12. Address of Designated Representative: _____
Street Address

City, State and Zip Code

13. Phone Number: (____) _____ - _____ **Home** (____) _____ - _____ **Work**

14. Expiration Date _____

This authorization will expire one (1) year from the date it was signed unless noted on the expiration date listed above. After the expiration of this authorization, a new authorization must be written in order to be valid. You may cancel this authorization in writing at any time.