ALTERWOOD ADVANTAGE
Quality Care. Better Health.

Member Authorization for Disclosure of Protected Health Information and Personal Representative(s) Request

MEMBER AUTHORIZATION FORM

This member authorization form allows Alterwood Advantage and any of its subsidiaries, and affiliates and their respective employees to use and disclose information about my protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to carry out treatment, payment, or health care operations while I am enrolled in the plan. This authorization form also allows me, if selected, the ability to appoint a qualified individual of my choice to represent me on any claim or asserted right under any of Alterwood Advantage's programs.

Alterwood Advantage has provided me with a Notice of Privacy Practices, prior to my signing this form, which completely describes the uses and disclosures of my PHI and is in accordance with my right to review its practices before signing my authorization. I understand the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by either calling Alterwood Advantage Member Services Department at 667-262-9412 or toll free at 866-675-3944, 8:00 a.m. - 8:00 p.m. ET, 7 days a week from October 1 through March 31 and 8:00 a.m. - 8:00 p.m. ET, Monday through Friday from April 1 through September 30. TTY users please call 711. Or, by writing to Alterwood Advantage, Attention: Enrollment Department, P.O. Box 4175, Timonium, Maryland 21094. You can also fax a request to the Enrollment Department at 410-801-5706.

SECTION A – Member Acknowledgements

☐ I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while Alterwood Advantage is not required to agree to my requested restrictions, if it does agree, it is bound by this authorization.

☐ I understand Alterwood Advantage may refuse me services if I refuse to sign this authorization.

☐ I understand this authorization shall remain valid and in force for my enrollment with Alterwood Advantage until I revoke this authorization in writing (see Section E), or my enrollment is terminated with Alterwood Advantage.

☐ I understand I have the right to revoke this authorization at any time provided that I do so in writing, and I have read the directions on how to go about revoking this authorization in Section E.

☐ I understand Alterwood Advantage and any other entity working directly with Alterwood Advantage for the purposes of carrying out treatment, payment, or health care operations on my behalf may still use my PHI to complete any actions, if I decide to revoke my authorization in writing.

SECTION B – Level of Access

There are three (3) levels of access you may provide (select one or more below):

☐ **Appointment of personal representative(s) for information only.** I authorize my personal representative(s) to receive information from Alterwood Advantage about my benefits, premiums, services, providers, enrollment, and health plan operations, but they do not have the authority to act on my behalf in requesting services, filing a prior authorization, appeal, or grievance, or changing any of my demographic information.

☐ **Appointment of a personal representative(s) for limited actions.** I elect to appoint a representative(s) to 1) act as my representative in requesting health care services and/or payment of claims from Alterwood Advantage, 2) make any changes to the demographics in my membership record, including but not limited to address changes, telephone number changes, email address changes, and request for a replacement ID card, and 3) make any request; present or elicit evidence; obtain prior authorization, grievance, appeals, and claims information; and to receive any notice in connection with my authorization, grievance, appeal, and/or claim. I understand personal medical information related to my prior authorization, grievance, or appeal may be disclosed to the representative(s) indicated in Section D of this Member Authorization for Disclosure of PHI and Personal Representative(s) Request form.

☐ **Durable Power of Attorney/Legal Guardian/Other Legal Representative.** I have written legal documentation that authorizes certain individual(s) to act on my behalf in private affairs, business, healthcare decisions, contracts, finance, or some other legal matter. I am providing a copy of the legal document(s) and/or court order(s) with this form

If the remaining portion of this authorization form is not completed, as applicable, Alterwood Advantage will be unable to process your request. Incomplete forms will be returned. PLEASE PRINT.

SECTION C – Member Information

First Name: _____ Last Name: _____ M.I. _____

Member ID#: _____ Date of Birth: _____ (MM/DD/YYYY)

Address (including City, State Zip): _____

Daytime Phone:_____

SECTION D – Personal Representative(s) Information

Based on the "Level of Access" indicated above, I appoint the following individuals to access my PHI and/or be my Personal Representative(s) for Member Information identified in Section B above.

Personal Representative 1

First Name: _____ Last Name: _____ M.I. _____

Address (including City, State Zip): _____

Daytime Phone#: _____ Relationship to Member: _____

Personal Representative 2

First Name: _____ Last Name: _____ M.I. _____

Address (including City, State Zip): _____

Daytime Phone#: _____ Relationship to Member: _____

Personal Representative 3

First Name: _____ Last Name: _____ M.I. _____

Address (including City, State Zip): _____

Daytime Phone#: _____ Relationship to Member: _____

SECTION E – HOW TO REVOKE YOUR AUTHORIZATION?

To revoke this authorization, an Alterwood Advantage member must do so in writing. These requests should be mailed to: Alterwood Advantage, Attention: Enrollment Department, P.O. Box 4175, Timonium, Maryland 21094 or faxed to the Enrollment Department at 410-801-5706.

SECTION F – WHEN A MEMBER IS A MINOR, If Applicable

When a Member is a minor (less than 18 years old), the following section must be completed (check all applicable):

☐ 1. Member is married or emancipated
☐ 2. Information being authorized for release pertains to drug or alcohol treatment
☐ 3. Information authorized for release pertains to one of the following conditions and applicable state law permits the minor to receive treatment for these conditions without consent of parent/legal guardian:

a. General Medical and Dental Health
b. Mental Health
c. Sexually Transmitted Disease, including HIV/AIDS
d. Reproductive Health, including contraception, prenatal care, and abortion)

SECTION G – Member Signature or Member's Legal Representative

The individuals(s) identified in Section D above may receive my PHI, make decisions on my behalf as permitted by this authorization, and may receive a copy of this signed authorization form if they ask for it by writing to the address listed in Section E.

Check one of below that are applicable:

☐ I am the Member.
☐ I am the Member's Legal Representative or Parent/Legal Guardian.
☐ I am the Parent/Legal Guardian of unemancipated minor unless Section F.2. is selected and state law requires signature of Parent/Legal Guardian for drug or alcohol treatment.
☐ I am the Parent/Legal guardian of unemancipated minor unless Section F.3. is selected.

Signature: _____ Date: _____

Name (Print First & Last Name): _____