New England Center for Healthy Minds **DESIGNATION OF PERSONAL REPRESENTATIVE**

WHY IS THIS FORM NECESSSARY?
Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to authorize another individual and/or entity to act on your behalf as a personal representative to manage your health care affairs, specifically when it comes to the use and access of Protected Health Information (PHI). Please complete this form completely so that we may provide you with the correct information you are requesting.

Patient Name: _____ Date of Birth:_____

Address:_____ Phone Number:_____

MRN#:_____

1. Designation of Personal Representative. At my request, I hereby name the following individual as my personal representative and authorize my PHI be released to them:

Name:_____ Relationship to Patient:_____

2. Release of PHI. I authorize the following disclosures of my PHI to the individual listed above:

☐ My entire PHI
☐ Claims and Explanation of Benefits (EOB) Information
☐ Enrollment and Benefits Information
☐ Premium Payment Information
☐ Any Documents Related to an Appeal
☐ Mental Health & Substance Abuse Information
☐ All services for a specific date from (start date):_____TO (end date):_____
☐ Other (please list specific PHI):_____

_____

3. Reason for Release. The information may be released for the following reason(s) ("at the request of the requestor" is a sufficient description):_____

_____

4. Expiration of Request. This request will expire one year from date of signing, unless I specify the following:
☐ Date:_____ OR ☐ After specific event (i.e., surgery, end of pregnancy, etc.)_____

5. Revocation/Cancellation of Designation. I understand that I may revoke this request and/or cancel the designation at any time by notifying the New England Center for Healthy Minds in writing. I understand and acknowledge that revocations/cancellations of this designation shall not apply to information that has already been released or affect actions taken by New England Center for Healthy Minds prior to this request.

6. Rights. I understand and acknowledge this designation is voluntary and I may refuse to sign this designation. The Plan shall not condition treatment, payment, enrollment or eligibility for benefits upon receipt of this authorization.

7. Denial of Request. I understand and acknowledge **MY DESIGNATION OF A PERSONAL REPRESENTATIVE MAY BE DECLINED IF:** (1) the information I provide is not accurate; (2) this form is not completed in its entirety; and/or (3) I do not sign below. If the New England Center for Healthy Minds denies the request, it will provide me with a written explanation of the reason(s).

8. Acknowledgement. By signing below, I hereby designate the above named individual to act on my behalf in making health care and health care payment related decisions through the New England Center for Healthy Minds. The individual I name as my personal representative may be a family member, friend, attorney or unrelated party and will have access to my PHI, including diagnoses, medical procedures, medications, treating providers and information such as my date of birth and address. If the New England Center for Healthy Minds accepts this request, it will abide by the request from the date upon which the New England Center for Healthy Minds approves the request. The information described on this form is protected by law and shall only be used as indicated above, and shall not be re-used and/or re-disclosed by the New England Center for Healthy Minds without my further authorization, unless otherwise required and/or permitted by law. However, I also understand and acknowledge that the potential for the information disclosed pursuant to this designation may be subject to re-use and/or re-disclosure by the recipient and may no longer be protected by Federal privacy regulations. I understand and acknowledge this request shall not apply to information that has already been released or affect actions taken by the New England Center for Healthy Minds prior to this request. I further understand and acknowledge that the New England Center for Healthy Minds is not responsible for any action taken by any authorized recipient for the information released pursuant to this designation. The information described on this form is protected by law and shall only be amended as indicated above, unless otherwise required and/or permitted by law.

Signature:_____ Date: _____

If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative signed by the Member naming you as a personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.

Signature of Personal Representative: _____

Print Name:_____ Date: _____

Relationship: ☐ Parent/Legal Guardian ☐ Personal Representative ☐ Other:

TO BE COMPLETED BY NEW ENGLAND CENTER FOR HEALTHY MINDS

☐ Request is Approved. Effective Date:_____

☐ Request is Denied. Reason:_____

☐ Additional Comments:_____

New England Center for Healthy Minds Representative Signature:_____