AUTHORIZED REPRESENTATIVE FORM
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (ADHI) (MEDICAL COVERAGE)

CHAND
Comprehensive Health Association of North Dakota

Section A: Purpose of Form
No information needed.

Section B: Member Information
Please complete all items of information in this section to include your Subscriber ID exactly as it appears on your card, full name, address and daytime telephone number where you can be contacted. If the pre-printed information is incorrect, please note changes.

Section C: Authorized Use and/or Disclosure
By completing this form, you are allowing CHAND to use and disclose your protected health information.

Authorized Representative
Indicate the complete name, daytime 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 the additional form.

Section D: Type of Information
You must indicate or describe the information to be disclosed. Check the box that best describes your request.

All My Information*: If you check this box, CHAND may disclose all information related to the provision of payment for health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all your information.

Only Limited Information*: By checking this box, you indicate you want only specific information to be disclosed. Check the appropriate box. If there is not an appropriate box, check the Other box and describe the specific information to be disclosed in the space provided.

*Does not include records protected by 42 C.F.R. Part 2. Requests for use and disclosure of these records should use the Authorization to Release Information 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.

Return completed forms by:
- Fax: (701) 282-1888
- Mail: CHAND Service Center
  4510 13th Ave S
  Fargo, ND 58121

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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 call the number on the back of your member ID card.

Return completed forms by:

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- Mail: CHAND Service Center
  4510 13th Ave S
  Fargo, ND 58121

Section A: Purpose of Form

This form is used to document the designation of an Authorized Representative(s) 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 Blue Cross Blue Shield of North Dakota to use and disclose my health information with the Authorized Representative(s) designated on this form.

Section B: Member Information

Please type or print clearly. This individual should sign Section F.

Member ID															Daytime Phone Number		
Last Name			First Name										MI	Suffix	Birth Date (mm/dd/yyyy)		
Address																	
City													State		ZIP Code		

Section C: Authorized Use and/or Disclosure

By signing this form, I am allowing CHAND to use and disclose my health information with the Authorized Representative(s) designated on this form. 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 use and disclose my health information without my authorization.

Authorized Representative #1 *Must be someone other than self*

Last	First	MI	Suffix	Daytime Phone Number
Address				
City		State		ZIP Code
Relationship to Member in Section B				

Authorized Representative #2 *Must be someone other than self*

Last	First	MI	Suffix	Daytime Phone Number
Address				
City		State		ZIP Code
Relationship to Member in Section B				

Section D: Type of Information

I allow the following information to be used or disclosed by CHAND on my behalf.
Select either "All My Information" or "Only Limited Information." Do not choose both.

☐ All My Information* Includes premium, billing, payment, health, diagnosis, claims, doctor and other provider information, including sexually transmitted disease, AIDS, HIV, behavioral, mental health and other sensitive medical information that applicable law may protect.

OR

☐ Only Limited Information* By checking this box you indicate you want only specific information to be used and disclosed. Check the appropriate box. If there is not an appropriate box, check the Other box and describe the specific information to be used and disclosed in the space provided. (check all that apply)

- ☐ Appeal Information
- ☐ Benefits and Coverage
- ☐ Premium Billing and Payment
- ☐ Claims and Payment
- ☐ Eligibility and Enrollment
- ☐ Pre-certification and Pre-authorization
- ☐ Referral
- ☐ Pharmacy
- ☐ Other _____

NOTE: Does not include alcohol/substance abuse records protected by 42 C.F.R. Part 2, or psychotherapy notes. Requests for use and disclosure of these records should use the Authorization to Release Information Form.

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 member ID card. I understand that my revocation of this authorization will not affect any action that you have already taken or any information that you have already released, based upon this authorization before you 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, whom 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 treatment, payment, enrollment or eligibility for benefits is not conditioned on receiving this authorization.

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.

Printed First Name	Printed Last Name
Signature	Today's Date (mm/dd/yyyy)