The attached Authorized Representative Form – HIPAA-3 should be completed if you do not have a valid Power of Attorney authorizing an individual to obtain or discuss your protected health information (PHI) with a Foreign Service Benefit Plan (FSBP) representative.

Section A is to be completed by the Member who is appointing the Authorized Representative(s). Be sure to include either your Social Security Number or member ID.

Section B provides a brief explanation of the type of PHI that your Authorized Representative(s) may obtain.

Section C includes the Intended Use or Disclosure statement. This section should also be used to provide the name, address, telephone number and relationship of the person(s) you have designated to serve as your Authorized Representative(s). You may select a primary and alternate representative, providing the same information for both.

You may also limit the information that may be released under this authorization by completing the **Limitations on Disclosure** section on page 2.

Section D provides guidelines regarding the Expiration and Revocation of this authorization. You have the right to cancel or revoke the authorization at any time, but it must be done in writing. This authorization will automatically expire two years following the termination of your health insurance with the FSBP.

Section E only requires your signature, which confirms your authorization that we may disclose your PHI to the individual(s) listed in **Section C**. The form will be considered invalid if it is received by the Plan unsigned.

Mail your signed, completed form to the Plan at 1620 L Street, NW, Suite 800, Washington, DC 20036 or fax us the form at (202) 833-4918. We will not be able to discuss your PHI with your Authorized Representative(s) until the signed Authorization Form is received in our office.

AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION
AUTHORIZED REPRESENTATIVE FORM ─ HIPAA-3

This form is used to confirm a Member's permission that AFSPA may discuss or disclose their protected health information to a particular person who acts as their Authorized Representative. Use of their information is strictly limited to that purpose described above.

Section A: Member Information

By signing this form in Section E below, I understand and agree that the Plan may release my personal health information as defined in Section B below to my Authorized Representative(s) named in Section C below.

Member Name (*last, first, mi*):____

Address:____

Telephone Number:___________________ **Member SSN/ID:**________________________

E-mail Address:____

Please Note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner, a clinical personal health care representative or a living will, please discuss this with your primary care physician or your attorney. The Plan will not condition benefits payments, enrollment, or eligibility for benefits on the execution of this form.

Section B: Type of Information

Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information (but not including any psychotherapy notes).

Section C: Authorized Use and/or Disclosure

Intended Use or Disclosure: I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name (*last, first, mi*):_____________________________ **Telephone Number:**_______________

Address:____

Relationship to you:____

Authorized Representative #2:

Name (*last, first, mi*):_____________________________ **Telephone Number:**_______________

Address:____

Relationship to you:____

Limitations on Disclosure: I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

____

____

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____

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire two years following the termination of my health plan enrollment.

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, I must revoke this authorization **<u>in writing</u>** by giving written notice of my decision to the health plan contact listed below. I understand that my revocation of this authorization will not affect any actions 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.

Contact Person:

American foreign Service Protective Association Privacy Official
1620 L Street, NW
Suite 800
Washington, DC 20036-5629
Telephone: (202) 833-4910 Fax: (202) 833-4918

Section E: Signature/Authorization

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request of the health plan and its administrator. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature:___________________________________ **Date:**_____________________________

Please return the signed Authorized Representative Form to:

American Foreign Service Protective Association Privacy Official
1620 L Street, NW
Suite 800
Washington, DC 20036-5629
Telephone: (202) 833-4910 Fax: (202) 833-4918

You are entitled to a copy of this Authorization Form after you sign it.