



Member Designated Representative Form

Your personal health information is confidential. As permitted by the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), your completion of the attached Member Designated Representative Form permits a Coventry Health Care plan* to provide your personal health information to the person(s) you name on the form. For instance, you may want to designate your spouse, your broker, a family member or a friend to assist you with your health care benefits. This form does not permit the Coventry Health Care plan to release information to anyone except the individual or entity you name on the attached form.

Coventry will **NOT** release information pertaining to HIV/AIDS, alcohol or substance abuse treatment or mental health treatment (all which by law, may require a special form for release), even if a specific claim or authorization question from the person named below is raised. This information will only be released to you or your legal representative (such as legal guardian) unless you specifically authorize the release of such information. You will need to complete an Authorization for Use or Disclosure form to do so.

*Note: "Coventry Health Care plan" includes the licensed subsidiaries of Coventry Health Care, Inc., including: Altius Health Plans, Inc., Cambridge Life Insurance Company, Carelink Health Plans, Inc., Coventry Health Care of Delaware, Inc., Coventry Health Care of Georgia, Inc., Coventry Health Care of Iowa, Inc., Coventry Health Care of Nebraska, Inc., Coventry Health Care of Pennsylvania, Inc., Coventry Health Care of Louisiana, Inc., Coventry Health and Life Insurance Company, Coventry Health Care of Kansas, Inc., First Health Group Corp., First Health Life & Health Insurance Company, First Health Services Corporation, Group Health Plan, Inc., HealthAmerica Pennsylvania, Inc., HealthAssurance Pennsylvania, Inc., HealthCare USA of Missouri, L.L.C., OmniCare Health Plan, Inc., PersonalCare Insurance of Illinois, Inc., Southern Health Services, Inc., and WellPath Select, Inc.

Member Designated Representative Form

As permitted by the Health Insurance Portability and Accountability Act ("HIPAA"), I hereby designate the person named below to receive my personal health information, including, but not limited to, procedures, and treating providers, from the Coventry Health Care plan listed below for purposes of assisting with or facilitating my health care benefits. I understand that this information may include Protected Health Information and other information protected by HIPAA and other laws.

I understand and agree that:

- Coventry may share my personal health information with the person(s) listed below.
- This authorization does not provide my Designated Representative with any authority over any treatment or direct-care decisions.
- Once released to my Designated Representative, my personal health information may no longer be protected by those laws, and my Designated Representative could share my personal health information with others.
- I am not required to complete this form and my information will be not be shared with the Designated Representative unless I sign this form.
- This designation will be effective until the termination of my health plan coverage or until I notify Coventry otherwise.
- I may change or cancel this request at anytime by sending my change in writing to the address below.
- By signing this form, I release Coventry from any liability of any nature in connection with its release of my personal health information to the person(s) designated below and any use, misuse or secondary release of such information by the person(s) named below.

I have fully read this Form and hereby designate the person listed below as my Designated Representative.

Member Name: _____

Health Plan Name: _____ Member ID Number: _____

Member Signature*: _____ Date: _____

*If someone other than the Member is signing this form (e.g., a legal guardian), please provide your relationship to the Member and attach any appropriate documentation of authority.

Designated Representative Information:

Designee Name: _____ Phone _____

Designee Address: _____ Relationship to Member _____

City, State, Zip Code: _____

Send this form to:
HealthAmerica/HealthAssurance.
PO Box 7754
London, KY 40742

Please keep a copy of this form for your records