NC HEALTH CHOICE

DESIGNATION OF AUTHORIZED REPRESENTATIVE

If the Health Choice recipient is <u>under age 18</u>, please fill out this section:

I, _____, acting on behalf of _____
(Name of recipient's legal representative) (Name of Health Choice recipient)

in my capacity as _____
(Authority to act on behalf of the recipient, e.g., parent of minor child, power of attorney)

hereby give permission for _____
(Name of Authorized Representative)

_____
(Address and phone number of Authorized Representative)

to act as an Authorized Representative on behalf of the above-named Health Choice recipient.

If the Health Choice recipient is <u>age 18</u>, please fill out this section:

I,_____, hereby give permission for _____
(Name of Health Choice recipient) (Name of Authorized Representative)

_____
(Address and phone number of Authorized Representative)

to act as an Authorized Representative on my behalf.

I understand that the Authorized Representative:

- will have the ability to speak on the recipient's behalf regarding the recipient's participation in the Health Choice program;
- may view and/or discuss any information contained in the recipient's file related to the recipient's participation in the Health Choice program; and
- may receive protected health information as detailed in the accompanying Authorization to Disclose Health Information (attached).

I understand that I may revoke this Designation of Authorized Representative at any time by giving notice to the Division of Medical Assistance.

Signature:_____ Date:_____

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth_____

NCHC ID #_____ Client SS # *(Optional)*_____

I _____ hereby authorize
(Client or Personal Representative)
_____ to disclose specific health information
(Name of Provider/Plan)
from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)
_____

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by_____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*