

## NuStart Personal Representative Designation

The purpose of this form is to designate a patient's Personal Representative(s) for discussion and disclosure of Personal Health Information. The designation is voluntary and in no way affects benefits, claims processing and payment, or eligibility status.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Patient's acknowledgement of receipt

The **NuStart** Notice of Privacy Practices provides a thorough explanation of how we may use and disclose your protected health information, as well as your rights as a patient. I have received a copy of the **NuStart** Notice of Privacy Practices.

### Type of information

**NuStart** may discuss or release Personal Health Information to the Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through **NuStart**.

### Authorized use and/or disclosure

I authorize **NuStart** to release Personal Health Information to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider or other person subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. **NuStart** is not responsible should my Personal Representative further disclose my protected Personal Health Information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating a "no limitation" on disclosure of Personal Health Information.

Disclosure limitations: \_\_\_\_\_

### Expiration and revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan Administrator. Revocation will not affect any action that **NuStart** has taken or any information that has already been released based upon prior authorizations

### Designation of personal representative(s)

Name of authorized person	Relationship to patient	Phone Number
1)	1)	1)
2)	2)	2)
3)	3)	3)

I have read and understand the content of this form. My signed authorization is voluntary and acknowledge that the information released may include protected and individually identifiable information about me.

\_\_\_\_\_  
Signature of patient/legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name & description of legal representative relationship to patient