St Luke's HEALTH PLAN

PO Box 1739
Boise, ID 83702-5809

Designation of Authorized Representative

Use this form to appoint someone as your Authorized Representative. When you appoint someone as your Authorized Representative, they can act on your behalf. They will also have access to your protected health information (PHI) as it relates to the topic you specify below. Please note we cannot share any information about you with someone else, nor can someone else act on your behalf, unless we receive a signed copy of this form.

Claimant Name (print) **Member ID #**

I hereby authorize St. Luke's Health Plan to recognize the person named below as my representative for the purposes described below, and to disclose relevant health information to:

(Name of person representing you) **(Telephone Number)**

(Street Address) **(City, State, Zip Code)**

☐ All Medical claims ☐ All Dental claims

☐ All Appeals ☐ Other (please be as specific as possible):

I understand that this Authorization does not ensure that the person I am authorizing to receive health information about me will treat such information as confidential. **I understand that I may revoke this Authorization at any time by submitting a Cancellation of Authorized Representative Form to St. Luke's Health Plan.** This Authorization is valid for one year following the date on which it is signed below unless a different expiration date or event is indicated here _____ or upon receipt by St. Luke's Health Plan of a Cancellation of Authorization Form.

Claimant's Signature **Date**

A copy of this authorization form will be sent to your designated representative at the address listed above.