NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN
20547 Waverly Court, Ashburn, Virginia 20149
Brian L. Renfroe, President ● **Stephanie M. Stewart,** Director

Designating an Authorized Representative

In accordance with the requirements of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are sending you this important notice to let you know about our privacy policy and to give you – and your family members (age 18 or older, or as determined by state law) – an opportunity to name an Authorized Representative. When you designate an Authorized Representative, you are giving us permission to discuss your enrollment and claim-related information with that person.

As a health plan, we are permitted to disclose certain information to medical providers and our business partners as part of our daily operations. Permitted and required disclosures are outlined in our Notice of Privacy Practices. Generally, we will not release the protected health information of an enrollee or a family member (age 18 or older, or as determined by state law) – not even to a spouse, parent, child or friend who calls us at the enrollee's or family member's request – unless we have authorization on file.

Each family member (age 18 or older, or as determined by state law) that wishes to name an Authorized Representative must complete an authorization form. Enclosed are two forms. If you need additional forms, please photocopy the form or download it from our website: www.nalchbp.org.

You are not required to complete a form, but if you and your family member are covered by the Plan and we do not have the caller's name on file as your Authorized Representative, we will not discuss your personal information, when someone calls on your behalf. You may want to designate an Authorized Representative even if you usually handle your own claims inquiries. That way, whether you call or an Authorized Representative calls for you, we'll be able to help. If the form is not filled out correctly or does not specifically identify the information to be disclosed, the form shall not be honored.

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HIPAA Authorized Representative Form

This form allows you to give the NALC Health Benefit Plan (NALC HBP) authorization to disclose your protected health information (PHI) to a person that will act as your Authorized Representative. Each adult family member or dependent, determined by state law, who wishes to appoint an Authorized Representative must complete a separate authorization form. If you need additional forms, you may copy this form or go to www.nalchbp.org.

I understand that the Plan will not disclose my PHI, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my PHI to the person(s) named in this form for the purpose(s) set forth herein. I understand that the information disclosed pursuant to this authorization may no longer be protected by federal or applicable state privacy laws, and my Authorized Representative may further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary. I understand that I have the right to limit the information you release under this authorization, or I may allow an Authorized Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described within this form.

Please note: This authorization does not give your Authorized Representative authority, either implied or direct, over any treatment or direct care decisions. You are entitled to a copy of this completed form. If this form is not filled out correctly and completely, it will not be honored. **Please sign and complete this form and return it to: Privacy Officer, NALC Health Benefit Plan, 20547 Waverly Ct, Ashburn, VA 20149.**

My Name _____ NALC HBP Member ID _____

Daytime Phone _____ Date of Birth _____

Authorized Representative

Last Name _____ First Name_____

Phone Number _____ Relationship to You_____

Release the following information about me (check all that apply):

☐ Entire Claims Record ☐ Claims Record from (specify dates) _____ to _____

☐ Specific Information (please note): _____

_____

For the purposes of (check all that apply):

☐ Eligibility/Benefits Only ☐ Member Portal ☐ Legal Investigation/Action ☐ Other: _____

☐ This authorization expires: _____ ☐ Has no expiration

I understand that this authorization will not expire unless I provide an expiration date. I understand that I have the right to revoke or end this authorization at any time by giving written notice of my decision to the Privacy Officer at the address provided in this form. Simply submitting a new authorization form designating another Authorized Representative will not revoke this authorization. I understand that my revocation of this authorization will not affect any action that NALC HBP has taken or information that has already been released, based upon the authorization, before you receive my request to revoke authorization.

Signature _____ Date _____