



**ASSOCIATION & SOCIETY
INSURANCE CORPORATION**

Corporate Office: 2301 Research Blvd. Ste.300 Rockville, MD 20850
Mailing Address: P.O. Box 2107, Rockville, MD 20847
301-816-0045 ♦ 1-800-638 -2610 ♦ fax 1-800-310-5514

Designation of Personal Representative

You may designate a personal representative who will act on your behalf in making decisions related to health care, which includes treatment and payment issues. This individual can be a family member, friend, lawyer, or unrelated party. You must complete, sign, and date, and submit this form to **ASI Corporation** before we can share your health information with your personal representative. This designation will be effective once it is entered into our systems, which is typically 5 business days from receipt.

Please print neatly to ensure correct processing and to prevent any delays in service.

1. Member Information

First Name: _____ Last Name: _____

Member's Address: _____

Member's Home Phone: _____ Work Phone: _____

Member's Date of Birth: _____

Member's Certificate #: _____

2. At my request, I designate the following individuals as my personal representative:

1. First Name: _____ Last Name: _____

Relationship to Member: _____

2. First Name: _____ Last Name: _____

Relationship to Member: _____

3. First Name: _____ Last Name: _____

Relationship to Member: _____

3. I authorize the following disclosure of my protected health information (PHI) to the person/organization listed above. Check all topics that apply:

- | | |
|--|--|
| <input type="checkbox"/> All of my information | <input type="checkbox"/> Claims and EOBs |
| <input type="checkbox"/> Enrollment and Benefits information | <input type="checkbox"/> Premium Payment |
| <input type="checkbox"/> Any documents related to an appeal | <input type="checkbox"/> Mental Health/Substance Abuse |

To further limit the information being shared, please be specific as possible when selecting the options below:

All Services for a specific date (provide dates of service): From: _____ To: _____

All Services from a specific health care provider (list Provider's name):

Other (please list specific PHI):

4. Expiration

I would like this designation to expire:

on _____ (Check this option if you want to specify an expiration
Date date for this designation.)

after a specific event has occurred (e.g. after heart surgery or at the end of a pregnancy):

This designation will expire when you policy ends or you revoke it.

5. Right to Revoke (cancel)

I understand that I may revoke this designation of a personal representative at any time by giving written notice to **ASI Corporation at P.O. Box 2107, Rockville, MD 20847-2107**. Revoking this designation will not affect any action that **ASI Corporation**, or others named or unnamed herein, took before **ASI Corporation** received my written notice of revocation.

6. Signature

I, _____ hereby authorize the use and/or disclosure of my identifiable health information as described above.

I understand that:

- this designation is voluntary and being made at the request of the individual; and
- the released information may no longer be protected by federal privacy laws and maybe redisclosed when my personal representative receives this information.

I have had full opportunity to read and consider the contents of this designation, and I confirm that the contents of this designation, and I confirm that the contents are consistent with my direction to **ASI Corporation**. I understand by signing this form, I am confirming my designation of a personal representative, and that **ASI Corporation** may use and/or disclose the protected health information described above to the persons name on this form.

Signature: _____ **Date:** _____

7. Please mail or fax this designation to:

**ASI Corporation
P.O. Box 2107
Rockville, MD 20847-2107**

Fax: 1-800-311-3124

Please keep a copy of this designation.
We will provide you with a signed copy of this designation on request.

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.