Designation of Authorized Representative Form

You have the right to appoint a representative, including an attorney to act on your behalf. This form is used to confirm permission to discuss with or disclose a person's protected health information ("PHI") held by the affiliated entities AultCare Corporation, AultCare Insurance Company (AIC), Aultra Administrative Group (AAG), and AultCare Health Insuring Corporation (AHIC) which also does business as PrimeTime Health Plan and AultCare HMO to a particular individual who acts as the person's personal representative. We are not always required to grant such access, but each request will be carefully reviewed and approved if warranted. Use of this information is strictly limited to that purpose.

Member Name: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

I hereby authorize the following person to act as my personal representative as indicated below. **(Must fill out).**

Name of Representative: _____ **Relationship**: _____

I would like my health information disclosed for the following reason(s):

_____

The information that may be used and/or disclosed is: (Must check one)

_____ All billing records concerning all medical care that I have ever received from my health care providers

_____ All billing records concerning medical care I received from my health care provider on: _____

_____ Other:_____

The following items must be checked to be included in the use and/or disclosure of health information pursuant to this Authorization (by leaving this section blank, I am imposing the following limitations on disclosure):

_____ (a) HIV/AIDS related information and/or records _____ (c) Genetic testing information and/or records

_____ (b) Mental health information and/or records _____ (d) Drug/alcohol diagnosis, treatment

I understand that if a person or entity that receives information pursuant to this Authorization is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release the affiliated entities AultCare Corporation, AultCare Insurance Company (AIC), Aultra Administrative Group (AAG), and AultCare Health Insuring Corporation (AHIC) which also does business as PrimeTime Health Plan and AultCare HMO from all liability arising from this disclosure of my health information. **Note: State Law mandates that Authorizations are limited to 30 months. This form will expire upon 30 months from the date of signature unless an earlier date is noted here.** _____

_____

I understand that this authorization is voluntary and that I may revoke this authorization at any time by providing written notice of such revocation to the Health Plan, except to the extent that action has been taken in reliance on this authorization.

I have had full opportunity to read and consider the content of this form. I understand that this authorization is consistent with my request. I understand that, by signing this form, I am confirming my authorization that the Health Plan may use and/or disclose my PHI to the person named as personal representative for the purpose as described above.

Member Signature: _____ Date: _____

Form must be signed by member. If form is signed by Power of Attorney or Legal Representative, a copy of documentation of position held must be attached to form.

Please return the completed form to: ATTN: Privacy Coordinator, PO Box 6029, Canton, OH 44706. 4-2015