My Care Family℠
MI FAMILIA DE CUIDADORES

Authorized Personal Representative Designation Request Form

Bold denotes required fields.

A. Member Information

1. Member Name	**2. Member ID (numbers and letters)**	**3. Date of Birth**
4. Address		
5. Cell Phone Number	6. Home Phone Number	**7. E-mail address**
8. Primary Language	9. Subscriber Name, *if different from member*	

B. Authorized Personal Representative Information

10. Name	11. Date of Birth
12. Mailing Address	
13. Cell Phone Number	**14. E-mail address**

15. Relationship

- ☐ Authorized Personal Representative
- ☐ Executor of Estate*
- ☐ Guardian*
- ☐ Parent
- ☐ Power of Attorney*
- ☐ Provider

** denotes supporting documentation required for processing*

16. Effective Date	**17. Termination Date**

Unless otherwise noted, this authorization remains in place as outlined in box 23.

C. Scope of Authorization Details

Please place your initials below next to the Protected Health Information (PHI) that AllWays Health Partners can discuss with your authorized Representative. Check all that apply.

☐ 18. All information contained in my Designated Record Set maintained by AllWays Health Partners, except for any specific, privileged information that I have noted in the space below:

☐ 19. All information concerning any current or future appeal or grievance that I or my designated representative initiated with AllWays Health Partners

☐ 20. I authorize my personal representative to obtain and release my clinical and claims data through a third-party app of my personal representative's choice. This may include any and all applicable data listed in Section C, Item 22. AllWays Health Partners has no control over third-party apps. Third-party apps are not subject to the same information privacy and security rules as AllWays Health Partners. For more information about selecting a third-party app, we encourage you and your personal representative to visit our Website at **allwayshealthpartners.org/interoperability**.

☐ 21. Other, please specify:

continued

C. Scope of Authorization Details (continued)

22. Please note that AllWays Health Partners will **not** release any of the following privileged information, unless you specifically consent to its release by initialing the specific category of information:

- ☐ All HIV/AIDS-related information, including test results and diagnosis
- ☐ Mention of or treatment for sexually transmitted diseases
- ☐ Mention of or treatment for pregnancy or termination of pregnancy
- ☐ Psychiatric/Psychological information
- ☐ Treatment for alcohol/drug use

23. **By submitting this form, you understand and agree that:**

A. You have the right to choose one or more persons to act on your behalf with respect to your Protected Health Information (PHI).

B. You authorize AllWays Health Partners and its contracted vendors to share your Protected Health Information with your Authorized Personal Representative as outlined above.

C. This form is **not** a Health Care Proxy and does **not** authorize your Authorized Personal Representative to make medical decisions on your behalf.

D. Once PHI is disclosed, AllWays Health Partners cannot guarantee that the Authorized Personal Representative will not re-disclose the information to a third party.

E. Modifications to the authorized permissions will require submission of a new form.

F. This authorization is voluntary and you may refuse to sign it or may revoke it at any time and for any reason by notifying AllWays Health Partners in writing. Refusing or revoking this authorization will not affect the commencement, continuation, or quality of your AllWays Health Partners' treatment, health plan enrollment, or benefit eligibility.

G. This authorization will remain in effect until either 1) the termination date you have indicated above, 2) through the end of your enrollment with AllWays Health Partners, or 3) until you provide a written notice of revocation to AllWays Health Partners.

H. If you submit a request to revoke this authorization, the revocation will be effective immediately upon AllWays Health Partners' receipt, but it will not apply to any actions taken prior to the date your request was received and processed.

I. This authorization will be effective upon receipt by AllWays Health Partners, but it will not apply to any actions taken prior to the date your request was received and processed.

D. Required Signatures

Member Signature _____ **Date** _____

Member must be at least 18 years of age or otherwise legally able to make such authorization.

Personal Representative Signature _____ **Date** _____

If someone other than the member is submitting this form, please complete the information below.

Name _____ **Relationship** _____

Address _____ **Email Address** _____

Signature _____ **Date** _____

If you are a legal representative other than a parent, supporting documentation of your status must accompany this document.

Return completed form by email, mail, or fax *(Please allow 10 business days for processing.)*

Email: customerservice@allwayshealth.org
Print, sign, scan, and then email the completed form.

Mail: AllWays Health Partners
Customer Service Department
399 Revolution Drive, Suite 820
Somerville, MA 02145

Fax: 617-526-1985

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Important Definitions

Appeal
A request for a health plan to review a decision on a denied benefit or payment due to clinical or administrative reasons. You may also file an appeal if you disagree with a decision by AllWays Health Partners to stop coverage for services that you are receiving.

Authorized Personal Representative
A third-party individual designated in writing to be granted the same rights as the Member when transacting with AllWays Health Partners, except for any specified limitations.

Designated Record Set
A group of records maintained by or for AllWays Health Partners that includes information contained in the enrollment, payment, claims adjudication, and case management record systems, as well as any other information used in whole or in part to make decisions about you, and includes records held by AllWays Health Partners' business associates that meet the definition of a Designated Record Set.

Executor of Estate
The individual responsible for managing the affairs of a deceased person's probate estate.

Grievance
Any oral or written complaint submitted to AllWays Health Partners or one of its utilization management designees by a member about care or service you received from AllWays Health Partners or from a participating provider. This type of complaint concerns the service you receive or the quality of your care and does not involve a dispute with a coverage or payment decision.

Guardian
A person who has the legal authority (and the corresponding duty) to care for the personal and property interests of another person.

Health Care Proxy
A legal document that allows a person to appoint someone they know and trust to make health care decisions if, for any reason and at any time, the person becomes unable to make or communicate those decisions.

Parent
The parent(s) on file with AllWays Health Partners.

Provider
A doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker authorized to practice and perform within the scope of their practice as defined by State law.

Power of Attorney
An individual granted with a legal document giving him/her the authority to act for another person in specified or all legal or financial matters and make decisions on the person's behalf.

Protected Health Information (PHI)
Any information about health status, provision of health care, or payment for health care that is created or collected by AllWays Health Partners or one of our business associates and can be linked to a specific individual.