

**Appointment & Recognition of Authorized Representative
and
Authorization for Representative to Receive or Provide Protected Health Information**

I, _____, _____, hereby
(Name of Member/Participant) (Policy ID Number)
appoint _____ to act:
(Name of Authorized Representative)

- (select one)* **On my behalf**
- On behalf of my covered child/dependent (under age 18)**
 Name of Child/Dependent _____

in connection with

- (select one)* **My claim(s) for coverage or benefits with respect to the following medical condition(s) or event(s)** _____,
- Any claim for coverage or benefits for any and all medical conditions I may have,**

including receipt of any approvals, authorizations or pre-certifications that are required before any medical services are provided under the terms of the **New West Health Services** group health plan in which I participate or the **New West Health Services** individual health insurance policy issued to me, as applicable.

I authorize my representative to receive any and all information from **New West Health Services** that is, or otherwise would be, provided to me, and to act for me or for my covered child/dependent named above, as applicable, in providing information to and appealing decisions by **New West Health Services** in connection with the claim(s) for coverage or benefits described above. The information that my representative may receive or provide under this Appointment and Authorization may consist of: (i) non-medical information (including, but not limited to, information related to eligibility, coverage, claims, benefits, providers, family members and demographics); (ii) medical information; and (iii) drug/alcohol abuse diagnosis, treatment and/or referral information. The information and records that may be disclosed under this Appointment and Authorization may include, but are not limited to, treatment plans, assessments, testing and test results, evaluations, discharge summaries, medication prescriptions and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. The medical information and records may include HIV/AIDS related health information and mental health information and records, but psychotherapy notes are not to be included.

I understand that I may revoke this Appointment and Authorization at any time by giving written notice of revocation to the Compliance Officer, New West Health Services, 130 Neill Avenue, Helena, MT, 59601. Revocation of this authorization will not affect any action **New West Health Services** took in reliance on this Appointment and Authorization before it received my written notice of revocation. I also understand that revocation of this Appointment and Authorization will

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have no effect on my treatment, payment for my treatment, enrollment in my health plan or policy, or my eligibility for benefits.

I understand that the protected health information described above may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I have had full opportunity to read and consider the contents of this Appointment and Authorization, and I understand that, by signing this form, I am confirming my appointment of the person or entity named above as my representative and my authorization of the use and/or disclosure of my protected health information as described in this form. Unless earlier revoked, this Appointment and Authorization is valid for a period of _____ (maximum 24) months from the date signed below.

This Appointment and Authorization must be signed by the member/participant whose health information may be released hereunder, if he or she is age 16 or older.

_____, 200____
(Member/Participant's Signature) (Date)

If this Appointment and Authorization is to release information for a minor child (under 18 years old) who is not emancipated or an incapacitated person, please sign below. If the relationship with the member/participant is other than as a parent of the minor child, a copy of the legal document establishing the signatory as the person's legal representative must be attached to this Appointment and Authorization.

Signature of Parent/Legal Representative/ Guardian Date

Printed Name Relationship to Individual

To be completed by Authorized Representative:

I, _____, hereby accept my
(Print Name of Authorized Representative)
appointment as Authorized Representative of the member/participant named above under the terms and conditions listed above.

(Signature of Authorized Representative)

(Street Address of Authorized Representative)

(City, State and Zip Code of Authorized Representative)

(Telephone Number of Authorized Representative)