HIPAA DESIGNATED REPRESENTATIVE AUTHORIZATION FORM

Your personal health information is confidential. Surency reserves the right NOT to release any information pertaining to certain medical services and diagnoses. This form is to document the designation of a HIPAA Designated Representative for a plan participant. This form authorizes the release of medical information to the named representative(s). This authorization does not provide your Designated Representative with any authority, either implied or direct, over any direct care decisions or account management.

Instructions

1. If you would like to allow a representative to speak with us about your personal health information, complete this form and return it to Surency.
2. **Your signature is required.**

Member Information

Last Name, First Name, MI (Please Print) _____ Employer _____ Social Security Number _____

Street Address _____ City, State, ZIP _____

HIPAA Member Designated Representative Information

Representative Name (First, MI, Last) _____

Street Address _____ City, State, ZIP _____

Additional Representative Name (First, MI, Last) _____

Street Address _____ City, State, ZIP _____

I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Surency will not disclose my personal health information to other parties without my written authorization or as permitted or required by law. As permitted by HIPAA regulations, I hereby designate the person named above to receive my personal health information, including, but not limited to, personal diagnoses, procedures and treating providers, from Surency. I understand that this information may include Protected Health Information and other information protected by HIPAA and other laws. I understand that if Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

I understand that I may revoke this authorization at any time in writing by giving written notice to Surency. I further understand that my revocation of this authorization will not affect any action that Surency has already released based upon this authorization and that information shared by Surency with my Designated Representative may no longer be protected by privacy laws.

I have read this form and hereby designate the person listed above as my Member Designated Representative.

Member's Signature (Required) _____ Date _____

Please retain a copy of this form for your records and send the original to Surency.

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773
866-818-8805 | Surency.com