AdventHealth Advantage Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myAHplan.com

COMMERCIAL APPOINTMENT OF REPRESENTATION

Member Name: _____ Plan ID Number:_____

Named Representative: _____

I attest that I am either the member named above, or their legal representative (attach documentation). With my signature below, I permit my "Named Representative" to perform the following activities and disclosures of my Protected Health Information for me until I specifically request otherwise.

Activity (Check all that apply)	**Special instructions**	**Effective Date**
☐ Filing a Grievance or Appeal		
☐ Choosing my providers		
☐ Accessing my enrollment information		
☐ Accessing my financial information		
☐ Accessing my claims and authorization		
☐ Other (please specify):		
☐ **ALL OF THE ABOVE**		
☐ Accessing my medical information		

I WOULD LIKE TO RECEIVE COPY OF THE RECORDS:

☐Paper Copy
- ☐Mail Records
- ☐Fax Records
- ☐Pick up by (Photo ID Required):

☐Electronic Copy
- ☐CD
- ☐Email (Secure)*

Email Address:

*Email is not a secure means of communication. I acknowledge that if I choose to receive my records via electronic means, the information will be encrypted. If a single transmission cannot accommodate size of file, records will be mailed unless otherwise specified.

☐ I understand the health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Member Signature: **Date:**

Representative Signature: **Date:**

Please return the completed form to:
AdventHealth Advantage Plans
Attn: Enrollment Department
6450 US Highway 1
Rockledge, FL 32955
Fax: 321.434.4226

If you have any questions or need further assistance, please call Customer Service toll-free at 1.844.522.5279 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

Uses and disclosures of protected health information not covered by the Notice of Privacy Practices* or other applicable laws will be made only with your written permission. If you provide us permission to use and disclose your protected health information, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written permission. We are unable to take back any disclosures we have already made with your permission, and must retain our records of services provided to you. If we disclose information to your personal representative, we cannot guarantee that your personal representative will not further disclose the protected health information to a third party, and that state and federal laws may no longer protect such information. Completion of this form does not affect the continuation or quality of treatment by Health First, enrollment in the health plan, or eligibility for benefits.

*The Notice of Privacy Practices can be found on the Health First Health Plans website or can be requested through Customer Service by calling 321.434.5665.

Health First Commercial Plans, Inc. is doing business under the name of AdventHealth Advantage Plans. AdventHealth Advantage Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations. 36194_MPINFO7490AH(09/19)