American Specialty Health

MTCDPA AUTHORIZED AGENT- Montana Residents Only

Please read this form carefully.Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

MEMBER INFORMATION

Member Name_____Date of Birth_____

Street Address[1]_____

City_____State_____Zip_____

Telephone_____Email_____

RECIPIENT INFORMATION

I authorize the following individual to exercise my Montana Consumer Data Privacy Act (MTCDPA) rights on my behalf:

Member Name_____Date of Birth_____

Street Address[1]_____

City_____State_____Zip_____

Telephone_____Email_____

ACKNOWLEDGEMENT & SIGNATURE

Signing this form means that I understand and agree to the following:

- I understand this Authorization is good for a period of one (1) year from the date I sign it. The Authorization will expire after that time period.
- I understand that I may revoke this Authorization at any time by notifying American Specialty Health (ASH) in writing at: Attn: Privacy Officer, American Specialty Health, 10221 Wateridge Circle, San Diego, CA 92121. If the Authorization is revoked, it will not have any effect on disclosures that were made before my notification revoking this Authorization was received by ASH.
- I understand that the Agent designated above may exercise any and all OCPA privacy rights normally extended to the member identified above.

American Specialty Health

ACKNOWLEDGEMENT & SIGNATURE CONTINUED

Signature _____ **Date** _____

Printed Name_____

Relationship to Member: ☐ **Self** ☐ **Other (complete information below)**

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation.

Name_____

Street Address_____

City_____ **State**_____ **ZIP** _____

Telephone_____

Description of Representative's Authority to Act/Relationship to Member (choose one):

- ☐ Member is a minor and I am the member's parent or legal guardian.
- ☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or
- ☐ I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).
- ☐ I hold Durable Power of Attorney for the member (please attach necessary documentation).
- ☐ Other (please describe and attach necessary documentation):_____

_____

RETURN THIS FORM TO:

Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746; **Email:** HIPAA@ashn.com

Please keep a copy of this form for your records. If you need a copy, you may request one from us.