AdventHealth
Advantage Plans

Health First Health Plans

This Authorized Representative Form allows an AdventHealth Advantage Plans member to choose a person to act on their behalf. The top part of the form must be filled out by the member. If the member is not able to fill out the top part of the form, his or her legal representative may fill it out. Documentation must be provided supporting the legal authority to act on the member's behalf.

This form must be completed and signed. Please send this form and documentation to privacyrequest@hioscar.com or by mail to: AdventHealth Advantage Plans, Attn.: Privacy Officer, P.O. Box 52146, Phoenix, AZ 85072-2146.

_____ _____
Printed Member Name Member ID Number

_____
Date of Birth

I authorize _____ to be my representative.
(Print Name of Authorized Representative)

Personal Representative Contact Information:

Telephone Number:_____

Address: _____

Email Address:_____

I authorize this person to do all of these things on my behalf:

- Discuss my Protected Health Information (PHI) and my health care
- Make changes to my Primary Care Provider (PCP)
- Request an appeal or grievance
- Fill out necessary forms
- Authorize the sharing and disclosure of PHI with third parties

I have the right to request a copy of this authorization or revoke this authorization at any time by sending a written notice to privacyrequest@hioscar.com or calling 1-855-672-2755. Revocation is effective upon Privacy Department's receipt of written notice or telephonic instruction.

_____ _____
Member or Legal Representative Signature (Print Legal Representative Name)

_____ _____
Member Address Member City, State, Zip

_____ _____
Member Telephone # Today's Date