AULTCARE'S PRIMETIME HEALTH PLAN

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM FOR INTEROPERABILITY

You have the right to appoint a representative, including an attorney, to act on your behalf. This form is used to allow your personal representative the ability to access your Protected Health Information ("PHI") held by the following affiliated entities: AultCare Insurance Company, AultCare Health Insuring Corporation dba PrimeTime Health Plan, AultCare HMO, AultCare Corporation, and Aultra Administrative Group (collectively referred to as "AultCare") through AultCare's Interoperability Application Programming Interface ("API"). We are not always required to grant such access, but each request will be carefully reviewed.

Member's Name		Member ID Number	
I HEREBY AUTHORIZE THE FOLLOWING PERSON TO RECEIVE MY PHI THROUGH THE INTEROPERABILITY API (MUST FILL OUT)			
Name of Representative		Relationship	
Representative's Email Address			
Representative's Mailing Address	City	State	Zip Code
Representative's Date of Birth			
If Representative is an AultCare Member, please provide Representative's AultCare Member ID:			

If your personal representative request is approved, the above named representative will receive follow-up correspondence with instructions of how to access your PHI through AultCare's Interoperability API.

I understand that for purposes of Interoperability and the use of 3rd party applications to access my PHI, AultCare **may not** be able to restrict access of certain pieces of information to the above named representative. If you desire any limitations in the disclosure of your PHI, those limitations must be described below in writing. I understand that AultCare may not be able to honor my restriction request. I also understand that by leaving this section blank, I am imposing no limitations on disclosure.*

*Any limitations described here: _____

_____

If my authorization is for use/disclosure of substance abuse information, I understand that the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Therefore, I release the affiliated entities AultCare Insurance Company, AultCare Health Insuring Corporation dba PrimeTime Health Plan, AultCare HMO, AultCare Corporation, and Aultra Administrative Group (collectively referred to as "AultCare") from all liability arising from this disclosure of my health information. **This form will expire upon 12 months from the date of signature unless an earlier date is noted here.** _____

Continued on next page.

I understand that this authorization is voluntary and that I may revoke this authorization at any time by providing written notice of such revocation to AultCare, except to the extent that action has been taken in reliance on this authorization. I also understand that AultCare does not require me to sign this form in order to receive treatment, payment, nor for enrollment or eligibility of benefits.

I have had the full opportunity to read and consider the content of this form. I understand that this authorization is consistent with my request. I understand that, by signing this form, I am confirming my authorization that AultCare may disclose my PHI to the person named as personal representative through AultCare's Interoperability API only. This authorization is not valid for other releases of PHI by AultCare.

Signature _____ Date _____

Form must be signed by member. If form is signed by Power of Attorney or Legal Representative, a copy of documentation of position must be in AultCare's receipt or attached to form. Please designate position held.