St Luke's™ Health Plan

PO Box 1739
Boise, ID 83702-5809

Designation of Authorized Representative - Group

Use this form to appoint someone as an Authorized Representative. When you appoint someone as an Authorized Representative, they can act on the Group's behalf. They will also have access to the Group's protected health information (PHI) as it relates to the topic(s) you specify below. Please note we cannot share any information about your Group with anyone else, nor can anyone else act on the Group's behalf, unless we receive a signed copy of this form.

Employer Name (print) | **Group ID #**

Employer Contact Name | **Employer Telephone Number**

Employer Address (Street name, City, State, Zip Code) | **Employer Email**

I hereby authorize St. Luke's Health Plan to recognize the person named below as my representative for the purposes described below, and to disclose relevant health information to:

Name of person or agency representing Group | **Telephone Number**

Street Address | **City, State, Zip Code**

☐ All Medical claims
☐ All Dental claims
☐ All Appeals
☐ Other (please be as specific as possible):

I understand that this Authorization does not ensure that the person I am authorizing to receive health information about me will treat such information as confidential. **I understand that I may revoke this Authorization at any time by submitting a Cancellation of Authorized Representative Form to St. Luke's Health Plan.** This Authorization is valid for one year following the date on which it is signed below unless a different expiration date or event is indicated here _____ or upon receipt by St. Luke's Health Plan of a Cancellation of Authorization Form.

Signature | **Date**

Printed Name

A copy of this authorization form will be sent to the employer at the address listed above.