Health First
Health Plans

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 authorizations		
❑ Accessing my medical information		
❑ Other (please specify):		
❑ **ALL OF THE ABOVE**		

Member Signature: _____ **Date:** _____

Representative Signature: _____ **Date:** _____

Please return the completed form to:
Health First Health Plans, Inc.
Attn: Enrollment Department
6450 US Highway 1
Rockledge, FL 32955
Fax: (321) 434-4226

If you have any questions or concerns, please contact our Customer Service Department, Monday through Friday from 8 a.m. to 5 p.m. at (321) 434-5665 or 1-800-716-7737. If you are hearing impaired, you can also contact us through the Florida TDD Relay Center at 1-800-955-8771 during the same hours.

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.