Designation of Authorized Representative Form

You have the right to appoint a representative, including an attorney to act on your behalf. This form is used to confirm permission to discuss with or disclose a person's protected health information ("PHI") held by the affiliated entities AultCare Corporation, AultCare Insurance Company (AIC), Aultra Administrative Group (AAG), and AultCare Health Insuring Corporation (AHIC) which also does business as PrimeTime Health Plan and AultCare HMO to a particular individual who acts as the person's personal representative. We are not always required to grant such access, but each request will be carefully reviewed and approved if warranted. Use of this information is strictly limited to that purpose.

Member Name:	Date of Birth:
ID Number:	Group Number:
I hereby authorize the following person to act	as my personal representative as indicated below. (Must fill out).
Name of Representative:	Relationship:
I would like my health information disclosed	for the following reason(s):
<u> </u>	ical care that I have ever received from my health care providers care I received from my health care provider on:
to this Authorization (by leaving this section	ncluded in the use and/or disclosure of health information pursuant blank, I am imposing the following limitations on disclosure): /or records (c) Genetic testing information and/or records ecords (d) Drug/alcohol diagnosis, treatment
care provider or health plan covered by federedisclosed and is no longer protected by the Corporation, AultCare Insurance Company (Insuring Corporation (AHIC) which also doe liability arising from this disclosure of my heare limited to 30 months. This form will	eceives information pursuant to this Authorization is not a health eral privacy regulations, the information described above may be ose regulations. Therefore I release the affiliated entities AultCare (AIC), Aultra Administrative Group (AAG), and AultCare Health is business as PrimeTime Health Plan and AultCare HMO from all alth information. Note: State Law mandates that Authorizations expire upon 30 months from the date of signature unless an
	intary and that I may revoke this authorization at any time by the Health Plan, except to the extent that action has been taken in
consistent with my request. I understand that	der the content of this form. I understand that this authorization is t, by signing this form, I am confirming my authorization that the to the person named as personal representative for the purpose as
Member 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 held must be attached to form.