MARYLAND SENIOR PRESCRIPTION DRUG ASSISTANCE PROGRAM

ASSIGNMENT OF PERSONAL REPRESENTATIVE

(Please fill out all fields completely. Form must be signed in order to be accepted)

Name:_____ Date:_____

Address:_____ Member ID:_____

_____

City, State Zip:_____

PLEASE NOTE: IT IS ONLY NECESSARY FOR YOU TO COMPLETE THIS FORM IF YOU WISH TO ASSIGN AN AUTHORIZED REPRESENTATIVE FOR YOUR MARYLAND SENIOR PRESCRIPTION DRUG ASSISTANCE PROGRAM ACCOUNT.

I_____

(Member Name) (Date of Birth) (SS Number)

authorize the Maryland Senior Prescription Drug Program to recognize:

_____

(Name of Representative) (Date of Birth) (Phone Number)

Address of Representative_____

_____

Relationship to Member_____

as my personal representative for the purpose of:

□ granting authorization to release my confidential information to persons other than myself during my lifetime or after my death

□ reporting any change in my address

□ reviewing my benefits

□ discussing payment of my premiums

□ any other reason

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my written instructions to revoke this authorization it will remain in effect indefinitely.

I hereby release the Maryland Senior Prescription Drug Assistance Program from all legal liability that might arise from the release of health information protected by the HIPAA privacy regulations under 45 CFR 164.500 – 164.534 or by any other applicable federal or state law. **Any further disclosure of my records other than what is outlined above is prohibited without my specific written authorization, except as otherwise permitted by the HIPAA privacy regulations or by any other applicable federal or state law**. I consider a photocopy of this authorization to be as valid as the original.

I understand that I may inspect the information to be disclosed as provided in 45 CFR 164.524.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this rule.

_____

(Member name - please print)

_____ _____

(Member Signature) (Date)