Please fax, email, or mail to:
Goldleaf Partners
PO Box 806
Brainerd, MN 56401

Email: benefits@goldleafpartners.com
Phone: 866.882.8442, opt. 5
Fax: 844.756.9743

AUTHORIZED REPRESENTATIVE (HIPAA) FORM

This form is to document the designation of an Authorized Representative for a participant. The form authorizes the release of medical information to the named representative. Send completed form to Goldleaf Partners and keep copy for your records.

1. Participant Information (Please print or type)

Employee's Name (First, MI, Last)

Social Security Number (Last 4 Digits Only) | Date of Birth (Month, Day, Year)

Employee Address

City, State, Zip

Employer Name

Email Address (If supplied, all account notifications will be sent via email) | Phone Number

This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any direct care decisions. We will not condition benefit payments, enrollment, or eligibility for benefits on the execution of this form.

Intended Use or Disclosure:
I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person named below for the purpose of assisting with or facilitating the coordination or payment of my health benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Expiration & Revocation:
I understand that I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person named below to remain my Authorized Representative, I must revoke this authorization **in writing** by giving written notice of my decision to Goldleaf Partners at the address listed above. I understand that my revocation of this authorization will not affect any action that you may have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

2. Authorized Representative (Please print or type)

Authorized Representative's Name (First, MI, Last)

Social Security Number (Last 4 Digits Only) | Date of Birth (Month, Day, Year)

Employee Address

City, State, Zip

Participant Signature | Date