Representative Authorization Form

I request and authorize Granite Alliance Insurance Company (PDP) and any of its parents, subsidiaries, or other affiliates and their respective employees to disclose Protected Health Information (PHI) to the representative listed below. I understand that if the representative authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal and state law governing the use and disclosure of identifiable health information.

The representative you give access to your account will have full access to all records. PHI provided under this authorization may include choosing to participate or opt out of Medication Therapy Management, ordering prescriptions, application or enrollment information, claim records, claim status and patient management information, diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, medical treatment or payment of your claims.

Member/Beneficiary (Name and Information of person whose protected health information is being disclosed)

Last Name	First Name	Birth date
Identification/Subscriber #	Medicare Beneficary Identifier (MBI)	Phone Number
Street Address	City, State	Zip

Representative (Persons/Organization authorized to receive your information)

Full Name/Organization Authorized	Relationship to Member/Beneficiary	Phone Number
Street Address	City, State	Zip

Expiration and Revocation

Expiration Date of this Authorization ___/ ___/ ___ or Expiration Event _____.
If you do not give an expiration date, this Authorization will stay active until one year from the date of signature.
You may revoke this authorization at any time by notifying us in writing at the address below. The cancellation will apply from the date we receive your written notification.

Signature

Print Member/Beneficiary Name	**Member/Beneficiary Signature**	**Date**

Send form to:

Please return completed and signed authorization form to Granite Alliance.

Mailing Address	Fax Number	Email Address
Granite Alliance P.O. Box 1382 Maryland Heights, MO 63043	888-656-8099	GAICHelp@magellanhealth.com

If you have any questions please contact us, Granite Alliance, at 1-855-586-2573 (TTY users call 711). We are available 24 hours a day, seven days a week.