Authorized Representative Form

SECTION A: MEMBER INFORMATION			
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
E-mail Address:	Daytime Phone Number:		
SSN/Identification Number:			

SECTION B: PURPOSE OF FORM

This form is used to document the designation of an Authorized Representative for a Member. This form authorizes the release of the Member's or dependent's vision health information to the Authorized Representative designated on this form. Completion of this form is entirely voluntary. Your enrollment in a vision health plan, eligibility for benefits, or payment of claims, will not be conditioned on giving this authorization.

SECTION C: TYPE OF INFORMATION

I understand that by completing this form I am allowing you to use my vision health information with and disclose it to my Authorized Representative designated on this form, for the purposes set forth below:

☐ Inquiries regarding eligibility and status of claims for benefits for the following dependent minor covered under my vision plan , _____on or after the effective date of this authorization.

☐ An appeal or denied claims with the date(s) of service [specify dates]: _____

☐ Other _____

SECTION D: TYPE OF INFORMATION

I understand that if my Authorized Representative is not subject to Federal or applicable State privacy laws, my vision health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my health information without my authorization.

AUTHORIZED REPRESENTATIVE			
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
E-mail Address:	Daytime Phone Number:		
Relationship to Member:			

SECTION E: Expiration and 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 in Section D to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to National Vision Administrators L.L.C. at the address listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it. I also understand that my revocation may not be effective in preventing release of certain health information to a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, who applicable law allows to have access to such health information without my written permission.

SECTION F: Signature/Authorization (Please sign date and return this form to the address below)

_____

Member Signature ***Print*** ***Date*** ***Witness Signature*** ***Print*** ***Date***

_____

Authorized Signature ***Print*** ***Date*** ***Witness Signature*** ***Print*** ***Date***

National Vision Administrators, L.L.C. (NVA)
Attn: Call Center Manager
PO BOX 2187
Clifton, NJ 07015
800.672.7723 / TDD: 888.820.2990

vARF11192019