PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

# Third Party Representative Designation

| PARTICIPANT INFORMATION | | |
|---|---|---|
| Full Name | ID/Last 4 of SSN | Program/Plan |
| | | |

I voluntarily consent and authorize Palco, Inc. to use or disclose my health information itemized below during the term, to the recipient, and for the purposes identified herein. Please note that Palco may communicate with the Authorized User on the below listed topics, but the Authorized User **cannot** act as the employer role on behalf of the Participant or enrolled Surrogate Employer.

| PROGRAM REPRESENATIVE / AUTHORIZED REPRESENTATIVE INFORMATION | | | |
|---|---|---|---|
| First Name | Middle Name | Last Name | |
| Social Security Number | Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female | |
| Physical Address (Street Address, Including Apt. #) | | | |
| City | State | Zip | County |
| Mailing Address (Street Address, Including Apt. #) – *if different than the physical address* | | | |
| City | State | Zip | County |
| Phone1 | Phone2 | Email | |
| Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone/Voicemail | | | |
| Relationship to Consumer: | Reason for Disclosure: | | |
| Term of Disclosure (if applicable):<br>Start date of this Authorization: ____/____/_____<br>End date of this Authorization: ____/____/_____ *If no end date, leave blank* | | | |
| Information to be Disclosed:<br>*(please select one)*<br>☐ All of my health information that Palco has in its possession, including information relating to any medical history, mental, or physical condition and any treatment received by me.<br>☐ Only the following limited information:<br>_____<br>_____ | | | |

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The participant understands that Palco cannot guarantee that the recipient will not re-disclose his/her health information to a third party who may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of the participant's information and that disclosure may render the Privacy Rule inapplicable to his/her information. The participant holds Palco harmless for any harm resulting to him/her from disclosure of this information. The participant understands that he/she may revoke this authorization at any time in writing to Palco. The revocation will be effective immediately to all disclosures made after receipt of the revocation. The participant understands that this authorization does not delegate or allow any individual other than the enrolled legal employer of record to preform employer duties such as reviewing/approving timesheets and signing enrollment documents.

_____

**Participant Printed Name**

_____

**Participant Signature**

_____

**Date**

*If the participant is unable to sign, please witness:*

_____

**Witness Printed Name**

_____

**Witness Signature**

_____

**Date**

***Please return this form to Palco via email: enrollment@palcofirst.com* or via fax to 1.877.859.8757.**