Authorized User Designation

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.

AUTHORIZED USER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number			
Address			
City	State	Zip	County
Phone	Email		
Preferred Method of Communication: ☐ Email ☐ Mail ☐ Phone / Voicemail			
Relationship to Participant:	Reason for Disclosure:		
Term of Disclosure (if applicable): Start date of this Authorization: __ __/__ __/__ __ __ __ End date:__ __/__ __/__ __ __ __ *If no end date, leave blank*			
Information to be Disclosed: *(please select one)* ☐ 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. ☐ Only the following limited information: _____			

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.

_____

Participant Printed Name

_____

Participant Signature

_____

Date

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

If the participant is unable to sign, please witness:

_____

Witness Printed Name

_____

Witness Signature

_____

Date