## **Enrollee Authorized Designee**

I hereby authorize Atlantis Health Plan, Inc. and their respective employees, agents and subcontractors to disclose my PHI and Insurance Record to the designee identified below.

M	ember ID	Last N	Last Name		First Name		Date of Birth		
St	reet Address			City	•	State		Zip	
Da	time Telephone Number				Evening Telephone Number				
A	uthorized designee to receive	e PHI/ Ins			ng to the Member				
La	st Name		First Name	:		Da	Daytime Telephone Number		
St	reet Address			City		State		Zip	
Re	elationship to Member								
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Signature of Member

<sup>\*</sup> Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.