INSTRUCTIONS FOR FILLING OUT THE MEMBER AUTHORIZATION FORM

Use the member authorization form to authorize Range Health to share a member's personal health information with an individual or organization not otherwise authorized to receive the information. Only the member or the member's personal representative can authorize the release of a member's personal health information (see description of personal representative below).

1. **Member Information:** Complete all information in this section for the member whose information is to be disclosed. **Note:** Name, date of birth, policy ID and address are all required fields. If you do not have the policy ID number, please provide the member's social security number.
2. **Authorization and Purpose:** You must identify the individual(s) or organization you wish to share the member's personal health information with. Range Health will only disclose personal health information to the named individual(s) or organization.
3. **Description of Information to Be Disclosed:** You may choose to authorize Range Health to share "All" of the member's personal health information or "Specific" information with the designated individual(s) or organization. If you choose "Specific" information, please identify the types of information to be disclosed (for example: benefit information, enrollment/billing information, claims information, etc.).
4. **Expiration:** Choose when you want this authorization to expire. If no expiration is specified, the authorization will expire 24 months after you sign it. Enter dates as mm/dd/yyyy. To revoke this authorization, send a written request using one of the contact methods listed below.
5. **Signature:** You must sign and date your own authorization form unless you are the legal personal representative* (see below) or the parent of a minor child. If the member is 18 years old or older, the member must sign and date his or her authorization form.

*** Personal Representative:** A personal representative is a member's legal guardian, someone who has power of attorney over the member's medical insurance decisions, or a parent (if the member is a dependent child under the age of 18 and not an emancipated minor). Also, a personal representative can be an executor, administrator or person legally authorized to act on behalf of a deceased member or the member's estate. Other than a parent acting on behalf of a dependent child under the age of 18 who is not an emancipated minor, ***Range Health requires a copy of the power of attorney or other court-initiated document as proof that we should recognize the individual named as the member's personal representative.*** For this form to be processed, it is important that a copy of any applicable power of attorney or other court-initiated document be included when you return this form to Range Health.

Unless directed otherwise, please return this completed and signed form to:

Range Health Member Services
Mail: P.O. Box 9018 • Boise, ID 83707-9018
Fax: 208-387-6676
Email: RHMemberServices@rangehealth.com

© 2026 Range Health, Inc.

H8267_16_4707_0926_C
Form No. 16-4707-RGH (09-26)

RANGE HEALTH®

MEMBER AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

****Please see instructions for filling out member authorization****

1. Member Information *(member whose information may be disclosed)*

Name: _____ Date of Birth: _____

Range Health ID#: _____ Program/Group#: _____

Street Address: _____

City/State/ZIP: _____ Phone: _____

2. Authorization and Purpose

At my request, I authorize Range Health to disclose the above member's personal health information (as described below) to:

Person(s) or Organization Receiving the Information: _____

Street Address: _____

City/State/ZIP: _____ Phone: _____

3. Description of personal health information to be disclosed

All ☐ Specific (describe): _____

4. Expiration

Choose when you want this authorization to expire. If you do not choose, the authorization will expire 24 months from date of signature.

Idaho residents: ☐ On this date: _____ ☐ When my coverage expires

Montana residents: Earlier expiration date, if desired: _____

5. Signature

I understand: If the person or organization that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the person or organization may not be obligated by state or federal law to protect it.

I may cancel this authorization in writing at anytime by sending a written request to Range Health. My cancellation of this authorization will not affect any action Range Health took before it received my request.

This authorization is voluntary. Range Health will not condition my enrollment in the health plan or eligibility for benefits on receiving this authorization.

Your Signature _____ Today's Date _____

If signed by a personal representative of the member, please complete the following and attach documentation of your legal authority to act on behalf of this member.

Name of Personal Representative (please print) _____

Phone _____

Relationship to Member: _____