DESIGNATION OF PERSONAL REPRESENTATIVE

You may designate a personal representative who will act on your behalf in making decisions related to health care, which includes treatment and payment issues. This individual can be a family member, friend, lawyer, or unrelated party.

Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete form.

1) I authorize: ____

(HEALTH INSURANCE PLAN/COMPANY)

2) To release the records of:

Name: ______________________________ Date of Birth: ____________

Membership Number: ___________________________

Address: ____

Home Phone: _______________ Work Phone: ______________

3) I hereby designate the following individual(s) as my personal representative:

A. Name of Individual: ________________________________

Address: ____

City, State, Zip: ___________________________________

Telephone: ______________________________________

B. Name of Individual: ________________________________

Address: ____

City, State, Zip: ___________________________________

Telephone: ______________________________________

C. Name of Individual: ________________________________

Address: ____

City, State, Zip: ___________________________________

Telephone: ______________________________________

D. Name of Individual: ________________________________

Address: ____

City, State, Zip: ___________________________________

Telephone: ______________________________________

Please read each of the following statements carefully before signing this document.

1. I understand that this designation will expire *when my coverage ends* unless I indicate an expiration date or I revoke it.

   Date to expire: ______________________

2. I understand that this designation is voluntary and being made at my request.
3. I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization that receives the information.
4. I understand that I may refuse to sign this designation form. My healthcare provider will not condition treatment and my health plan will not condition payment, enrollment, or eligibility on my signing this designation.
5. I understand that I may revoke this designation of personal representative at any time by sending a written notification to the Privacy Office at the address listed below, and this revocation will be effective for future uses and disclosures of protected health information. . However, I further understand that this revocation will not be effective for information that my health plan has already used or disclosed, relying on this designation.

Signature: ____________________________________ **Date:** __________________

If the person signing this form is not the member, or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.).

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please mail or fax this authorization to:

Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692

Please keep a copy of this designation for your records