Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

Member Name: _____ Member ID: _____
(LAST) (FIRST) (M.I.)

Address: _____

Telephone (with area code): _____

Date of Birth: _____ Social Security #: _____
(OPTIONAL)

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: _____

Address: _____

_____

Telephone: _____

What relationship is this person to you? _____

This person is to be afforded all of the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Sharp Health Plan at the following address:

Sharp Health Plan Customer Services
4305 University Avenue, Suite 200
San Diego, CA 92105

I further understand that any such revocation does not apply if that person or persons authorized to use or disclose my protected health information has already taken action on my behalf.

Date: _____ _____
Member's Signature

REVOCATION SECTION

I hereby revoke this designation of a personal representative.

Date: _____ _____
Member's Signature