Scripps | Health Plan Services

*Member MRN: _____

Plan Use Only

DESIGNATION OF PERSONAL REPRESENTATIVE

WHY THIS FORM? As required by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, you have a right to designate a person to act on your behalf with respect to your protected health information (PHI). By completing and signing this form, you are informing Scripps Health Plan Services of your wish to designate the named person on this form as your personal representative.

Member Information		
Member's Name and Address (please print)		
Member ID Number	Telephone Number	Date of Birth (MM/DD/YYYY)

Designation of Personal Representative: At my request, I hereby name the following individual as my personal representative:

Designee Name and Address (please print)	Relationship to Member	Designee Telephone Number

I authorize the named Designee to have access to my PHI in order to do the following related to my healthcare (check all that apply):

- ☐Make, change, or confirm appointments.
- ☐Sign the Request to Obtain a Copy/Authorization for the Use or Disclosure of Health Information form to request a release of my records and/or copies.
- ☐Speak with a care coordinator regarding the coordination of my care.
- ☐Speak with Scripps Health Plan Services regarding billing/claims.
- ☐Speak with Scripps Health Plan Services regarding referrals for care.
- ☐Submit an appeal/grievance on my behalf.
- ☐Other: _____

Note: This form does not take the place of an Authorization for Use and Disclosure of PHI, when requesting copies of records.

Is the Designee authorized to receive "Sensitive Information"?

☐ **NO** ☐ **Yes** Complete this section **ONLY IF** you wish to authorize disclosure of any of the following types of Sensitive Information (check all that apply):

☐Abortion	☐Alcohol/Substance	☐Genetic Information
☐HIV/AIDS	☐Mental Health	☐Pregnancy
☐Sexual, physical, or mental abuse		☐Sexually transmitted illness

Note to parents/legal guardians of minors twelve (12) years of age or older: You may be unable to obtain or authorize the use of disclosure of certain types of Sensitive Information about the minor without the minor's own written authorization. This may include the types of Sensitive Information listed above as well as information regarding infectious diseases, rape/sexual assault, and certain outpatient mental health counseling/treatment. If the minor is seventeen (17) years of age or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.

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Expiration of Designation	
This Authorization will remain in effect for one (1) year from the date of signatures on this form unless a different date is specified.	Date (MM/DD/YYYY)
Denial of Access to PHI. I understand and acknowledge **MY DESIGNATION OF PERSONAL REPRESENTATIVE MAY BE DECLINED IF:** (1) the information provided is not accurate; (2) this form is not completed in its entirety; (3) I failed to sign below; and/or (4) as prohibited by law.	
Member and Personal Representative Signatures	
Signature (Member)	Date (MM/DD/YYYY)
Print Name (Member)	
Signature (Personal Representative)	Date (MM/DD/YYYY)
Print Name (Personal Representative)	By signing, I affirm that I accept this appointment of personal representative.
TYPES OF ACCEPTABLE AUTHORIZATIONS: Legal authorization is required for someone other than the member to sign this form. These can include: Durable Power of Attorney (DPOA); Designation of Personal Representative (DPR); Conservatorship; Parent/Legal Guardian.	
If signed by other than the member, indicate authorization ☐DPOA ☐DPR ☐Parent/Legal Guardian ☐ Other: _____ Relationship to Member:_____	
Revocation of Designation of Personal Representative As required by the HIPAA Privacy Rule, you have the right to revoke a designated person from acting on your behalf with respect to your PHI at any time by notifying Scripps Health Plan Services in writing. Revoking this Authorization will not affect information that Scripps Health Plan Services used or disclosed before receiving your revocation request and any such revocation does not apply if the person authorized to use or disclose your PHI has already taken action on your behalf. If this Authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth (18) birthday.	
By completing this section of the form you are informing Scripps Health Plan Services of your wish to **REVOKE** the assigned designee, named person on this form, as your personal representative.	
Signature (Member)	Date (MM/DD/YYYY)
Print Name (Member)	

Please retain a copy of this Authorization for your records and return this completed form to:

USPS: Scripps Health Plan Services
Mail Drop: 4S-300
Attention: Customer Service
10790 Rancho Bernardo Road
San Diego, CA 92127

Fax: (858) 260-5844

Email: CustomerService@ScrippsHealth.org