

Personal Representative Form

Purpose: This form is used to appoint a personal representative for the Individual identified in Section A. HealthSCOPE Benefits will provide Protected Health Information (PHI) about the Individual to the appointed Personal Representative and provide that same Representative with the same PHI that is entitled to be provided to the Individual.

SECTION A: Individual requesting confidential communication.

Covered Employee's Name: _____ Employee's SSN: _____ - _____ - _____

Covered Employee's Employer: _____ Current Telephone: _____ - _____ - _____

Name of Individual Making Request: _____ Individual's SSN: _____ - _____ - _____

Current Address: _____

SECTION B: Identification of Personal Representative

You have the right to authorize that the PHI held by HealthSCOPE Benefits be released to and/or received by the Representative identified in this section. The Representative you identify below may not be subject to federal health information privacy laws. If this is the case, they may further release your PHI and federal information laws may no longer protect it.

This authorization is voluntary. HealthSCOPE Benefits will not condition your enrollment or eligibility for benefits on receiving this authorization.

You may revoke this authorization at any time by giving written notice to HealthSCOPE Benefits. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact HealthSCOPE Benefits' Customer Service Department for more information if you desire to cancel this authorization.

Please state your reason for making this request: _____

Personal Representative's Name: _____

Personal Representative's Relationship to Individual: _____

Personal Representative's SSN: _____ - _____ - _____ Representative's Telephone: _____ - _____ - _____

Personal Representative's Address (Note – all correspondence for the Individual making this request will be sent to the following address):

Address Line 1: _____

Address Line 2: _____

City : _____ State: _____ Zip Code: _____

SECTION C: Signatures.

I, _____, hereby swear that I am the individual listed above or that I have the legal authority to appoint a representative for the Individual listed. Further, I authorize the request and release of my confidential information held by HealthSCOPE Benefits, Inc. to my personal representative. By appointing the person named above as my personal representative, I understand that I am authorizing HealthSCOPE Benefits to provide this person with access to my protected health information (PHI), the right to talk to HealthSCOPE Benefits about my medical care, and the right to make decisions that will bind me.

Individual's Printed Name

Date

Individual's Signature

Date

If the Individual is unable to give consent because of physical condition or age, complete the following:
Individual is unable to give consent because: _____

I hereby accept the above appointment. I understand that federal and/or state confidentiality laws protect any protected health information (PHI) disclosed to me and I am prohibited from making any further disclosures without the specific authorization of the Individual.

Personal Representative's Printed Name

Date

Personal Representative's Signature

Date

To safeguard your privacy and insure no one other than the person you designate receives your PHI, this request must be notarized. (Notary services can often be provided free of charge at a bank with whom you maintain an account).

Date: _____ Notary Public Signature: _____

Notary Public Printed: _____ Commission Expires On: _____

Please submit this completed request to:

HealthSCOPE Benefits
HIPAA OFFICIAL
P.O. Box 1224
Little Rock, AR 72203

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.