

## 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, The Undersigned, Authorize:**

Health Plan/Insurer Name: \_\_\_\_\_

**2) To Release Information from the Records of:**

(Complete a separate form for each member whose information is releasable.)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Membership Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**3) I, the Undersigned, 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: \_\_\_\_\_

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

1. I understand that this designation will expire when my policy 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 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.).

If you need help completing this form please call 410-308-8300 or toll-free 1-800-853-9236.

Please mail or fax this designation form to:

CareFirst Privacy Office  
10455 Mill Run Circle, YRK - 06  
Owings Mills, MD 21117  
Fax: 410-505-6692

**Please keep a copy of the designation.  
We will provide you with a signed copy of this designation upon request.**

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 whom 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.