Designation of Personal Representative

CareFirst Medicare Advantage

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 type or print neatly. We will not process incomplete or illegible forms. Please keep a copy of this document for your records.

Please mail or fax this authorization to: CareFirst BlueCross BlueShield, Privacy Office, PO Box 14858, Lexington, KY 40512 Fax: 1-410-505-6692

DESIGNATION OF PERSONAL REPRESENTATIVE IS GIVEN TO			
Name of Health Insurance Plan **CareFirst BlueCross BlueShield Medicare Advantage**			
TO RELEASE RECORDS OF			
Last Name, First Name, MI			Member / Plan ID
Street Address			
City		State	ZIP
Home Phone	Work Phone	Date of Birth (mm/dd/yyyy) / /	
I HEREBY DESIGNATE THE FOLLOWING INDIVIDUAL(S) AS MY PERSONAL REPRESENTATIVE(S)			
Name of Individual		Phone	
Street Address			
City		State	ZIP
Signature of Appointee			
Relationship to member		Appointee Signature Date	

I hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I HEREBY DESIGNATE THE FOLLOWING INDIVIDUAL(S) AS MY PERSONAL REPRESENTATIVE(S)		
Name of Individual	Phone	
Street Address		
City	State	ZIP
Signature of Appointee		
Relationship to member	Appointee Signature Date	
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PLEASE READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT	
1. I understand that this designation will expire one year from my signature date. 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 health care 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 on page 1, 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
Must be the original signature of any person 18 years of age or older whose records have been requested. If this request is made by a personal representative on behalf of the individual, please attach a complete copy of the personal representative form or legal document indicating your legal authority to sign this form.	

Any mental health or substance use disorder 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 (42 CFR Part 2) and/or Washington, D.C. and Maryland mental health laws prohibit 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 and/or Washington, D.C. and Maryland mental health laws. 42 CFR Part 2 prohibits unauthorized disclosure of these records.