Scripps | Scripps Health Plan

*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 this form you are informing us of your wish to designate the named person 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	Relationship to Member

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

- ☐Make, change, or confirm appointments.
- ☐Sign the Request to Obtain Copy/Authorization for the Use or Disclosure of Health (form to request a release of my records and/or copies.)
- ☐Speak with a care coordinator regarding the coordination of my care.
- ☐Speak with the Scripps Health Plan regarding billing/claims.
- ☐Speak with the Scripps Health Plan regarding referrals for care
- ☐Submit an appeal/grievance on your 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 Recipient 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 Abuse	☐Genetic Information
☐HIV/AIDS	☐Mental Health	☐Pregnancy
☐Sexual, physical, or mental abuse		☐Sexually transmitted illness

Note to parents/legal guardians of minors 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 17 years of age or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.

Expiration of Designation	
This Authorization will remain in effect for one year from the date you sign it (below) unless a different date is specified here:	Date (MM/DD/YYYY)

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You have the right to revoke this Authorization at any time by notifying Scripps Health Plan in writing. Revoking this Authorization will not affect information we use or disclose before we receive your revocation request. I further understand that any such revocation does not apply if the person authorized to use or disclose my protected health information have already taken action on my 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.
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.
Name/Signature of Patient or Authorized Representative

Signature	Date (MM/DD/YYYY)
Print Name	

TYPES OF ACCEPTABLE AUTHORIZATIONS: Legal authorization is required for someone other than the patient to sign this form. These can include: Designated Power of Attorney (DPOA); Designated Personal Representative (DPR); Conservatorship; Parent/ Legal Guardian.
If signed by other than member, indicate authorization ☐DPOA ☐DPR ☐Parent/Legal Guardian ☐ Other: _____ Relationship to Member:_____
Revocation/Cancellation of Designation
Revocation/Cancellation of Designation. I understand that I may revoke this designation at any time by signing the revocation section of this form and returning it to Scripps Health Plan. I further understand that any such revocation does not apply if the person authorized to use or disclose my protected health information has already taken action on my behalf.

Signature	Date (MM/DD/YYYY)
Print Name	

Please keep a copy of this Authorization for your records, sign and return this completed form to:

Scripps Health Plan
Mail Drop: 4S-300
10790 Rancho Bernardo Rd
San Diego, CA 92127

Or you can fax it to: **858-964-3102**

Or you can email to: CustomerService@ScrippsHealth.org