PERSONAL REPRESENTATIVE REQUEST FORM

This form is used to **APPOINT A PERSONAL REPRESENTATIVE** who is authorized to discuss or disclose protected health information and other benefit information with Contra Costa Health Plan at the request of the individual **(Complete Sections 1-3)**

If you have any questions, please call the Member Services Department at 1-877-661-6230 (Press 2) (California Relay/TTY/TDD only, call 1-800-735-2929).

Please mail the completed form to: Contra Costa Health Plan, Member Services Department, 595 Center Avenue, suite 100, Martinez, CA 94553, **or fax it to** 925-313-6047 or email it to us at member.services@hsd.cccounty.us

SECTION 1. MEMBER IDENTIFICATION		
Name: (First, Middle, Last, Title)		**Member ID Number:**
Address: (including zip code)		**Date of Birth:** (Month/Day/Year)
Home Telephone Number: (including area code)	**Daytime Telephone Number:** (including area code)	**Gender:** Male Female

SECTION 2. INFORMATION ABOUT THE PERSONAL REPRESENTATIVE		
Name # 1: (First, Middle, Last)	**Date of birth:**	**Relationship:**
Address: (including zip code)	**Telephone Number:** (including area code)	
Name # 2: (First, Middle, Last)	**Date of birth:**	**Relationship:**
Address: (including zip code)	**Telephone Number:** (including area code)	

SECTION 3. MEMBER'S DESIGNATION OF PERSONAL REPRESENTATIVE	
I designate the person identified in section 2 to serve as my personal representative. By doing so, I authorize Contra Costa Health Plan (CCHP) to disclose my health information to my personal representative, as requested by my personal representative, so that he or she may act on my behalf for services provided by CCHP. This is a FULL disclosure authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This authorization is also for the disclosure of HIV test results, if any. These records will be disclosed to my personal representative unless specifically excluded below: (INITIAL) ____ Exclude HIV test results (INITIAL) ____ Exclude Substance Abuse treatment information (INITIAL) ____ Exclude Mental Health treatment information (INITIAL) ____ Exclude other: ______________ I understand that I may revoke this appointment and disclosure of health information at any time by writing to CCHP saying that I want to revoke my appointment of a personal representative, at the following address: Contra Costa Health Plan, Member Services Department, 595 Center Avenue, suite 100, Martinez, CA 94553**, or fax it to** 925-313-6047. **This personal representative designation expires on (enter Month/Day/Year)** ________________ (If no expiration date is provided, this delegation is in effect until revoked in writing).	
Member's signature:	**Date**