UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Designation of Authorized Personal Representative Form

Instructions

SECTION A: INFORMATION ABOUT YOU
Enter all information about you.

SECTION B: DESIGNATION OF AUTHOZED PERSONAL PRESENTATIVE
The Designation of Personal Representative (PR) form is used to designate a PR to act on your behalf with respect to personal health information (PHI) that pertains to you. The PR form is not valid unless it is filled out completely and signed. Please type or print the information.

1. Enter the name, address, gender, phone numbers, and date of birth of the PR.
2. You may either choose to authorize your PR to have restricted access to your PHI, or to allow your PR all the privileges that would be afforded to you with respect to your PHI. Check the appropriate box for your choice. If you wish to restrict the access your PR may have to your PHI, you must complete the description of the authority granted by you to your PR.
3. You may revoke the designation at any time. Revocations must be submitted to University of Michigan Health Plan (UM Health Plan) in writing. Revocation of the designation of a PR will not affect actions taken before UM Health Plan received the written request to revoke the designation.
4. If you want to make more than one designation of PR, please complete a separate form.

SECTION C: EXPIRATION
1. Fill in the date upon which the designation will expire (day, month, and year) or the event or activity that will trigger expiration of the designation. If not specified, PR will remain in effect until revocation.
1. You may revoke designations at any time. Revocations must be submitted to PUM Health Plan in writing. Revocation of a designation will not affect actions taken before UM Health Plan received the written request to revoke designation.

SECTION D: REVOCATION
You may revoke authorizations at any time. Revocations must be submitted to UM Health Plan in writing by completing the revocation section of this form. Revocation of an authorization will not affect actions taken before UM Health Plan received the written request to revoke authorization.

SECTION E: SIGNATURE
The designation must be signed and dated before it becomes valid. If the individual requesting the designation is someone other than the member, a description of the relationship to the member must be included.

SECTION A: INFORMATION ABOUT YOU

Subscriber's Name:			Member ID Number:
Address:			Gender: ☐ Male ☐ Female
City:	State:	Zip:	Date of birth:
Daytime phone number:		Evening phone number:	

SECTION B: DESIGNATION OF AUTHORIZED PERSONAL PRESENTATIVE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to nominate one or more persons to act on your behalf with respect to protected health information (PHI) that pertains to you. By completing this form, you are informing UM Health Plan of your wish to designate the names person(s) as your PR(s). If you would like to designate more than one PR, you will need to complete a form for each PR.

I (type/print name), hereby nominate the following person to act as my Authorized PR with respect to decision involving the use and/or disclosure of PHI that pertains to me. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this designation.

Personal Representative Name:			
PR Address:			PR gender: ☐ Male ☐ Female
City:	State:	Zip:	PR date of birth:
PR Daytime phone number:		PR Evening phone number:	

NOTE: The information given regarding your PR will be used for personal identification purposes only.

Check 1 box below:

☐ The authority of this person when acting as my PR is restricted to the following PHI: Describe in detail the PHI to be used and disclosed (providers, treatment dates, type of service, enrollment records, etc.)

☐ My PR is afforded all the privileges that would be afforded to me with respect to my PHI including information related to but not limited to; pharmacy, mental health and substance abuse, HIV/AIDS, transplant, and genetic testing.

NOTE: If PHI is disclosed under your authorization to persons or organizations not subject to federal privacy laws, it may be re-disclosed and no longer protected.

SECTION C: EXPIRATION

This authorization will expire on: _____; or when the following occurs: _____

_____

I understand that I may revoke this designation at any time by sending a written notification to UM Health Plan at the address below. I further understand that any such revocation does not apply to the extent that UM Health Plan has already acted in reliance on this designation.

SECTION D: REVOCATION

I, _____ hereby revoke _____ as my
Member Name/Number PR Named PR Named
authorized personal representative as of _____.
Enter date of revocation

_____
Subscriber's signature Date

NOTE: If the above signature is that of a patient's representative, UM Health Plan must complete the following:

I have verified the identification of:

Name of Personal Representative:	Documentation type (e.g., driver's license):	Document number (e.g., driver's license number):

_____
UM Health Plan Associate Signature Date

SECTION E: SIGNATURE

_____
Subscriber's signature Date Relationship to Designated PR

Please return to: University of Michigan Health Plan
PO Box 30377
Lansing, MI 48909-7877
Fax: 517-364-8411

For Health Plan Use Only		
Accepted ☐ Denied ☐	Date logged:	Reviewed by:
If denied, why:		
Sent to:		Date sent: