



## REQUEST FOR PERSONAL REPRESENTATIVE

This form cannot be processed unless all fields are filled out COMPLETELY and signed.

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

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

Patient Phone Number: \_\_\_\_\_

\_\_\_\_\_

Named Representative (s): \_\_\_\_\_

Under federal law, you have the right to nominate one or more persons to act on your behalf with respect to your health information. By completing this form, you are informing UCERA of your wish to designate the named person (s) as your personal representative (s).

I attest that I am either the patient, or their legal representative (attach documentation). With my signature below, I permit my "Named Representative (s)" to perform the following activities and disclosures of my Protected Health Information for me until I specifically request otherwise.

Activity (Check all that apply):	Special instructions:	Effective date:
<input type="checkbox"/> Filing a Grievance or Appeal	_____	_____
<input type="checkbox"/> Choosing my providers	_____	_____
<input type="checkbox"/> Accessing my enrollment information	_____	_____
<input type="checkbox"/> Accessing my financial information	_____	_____
<input type="checkbox"/> Accessing my claims and authorizations	_____	_____
<input type="checkbox"/> Accessing my medical information	_____	_____
<input type="checkbox"/> Other (please specify):	_____	_____
<input type="checkbox"/> <b>ALL OF THE ABOVE</b>	_____	_____

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Representative (s) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Please return complete form to:

UCERA

Attn.: Health Information Department

677 Ala Moana Blvd. Suite 1001

Honolulu, HI 96813

Fax (808) 536-7315

If you have any questions or concerns,

please contact our Health Information Management Department,

Monday through Friday from 8 am to 4:00 pm HST at (808) 469-4900.

email us at: medrecs@ucera.org

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