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:
☐ Filing a Grievance or Appeal		
☐ Choosing my providers		
☐ Accessing my enrollment information		
☐ Accessing my financial information		
☐ Accessing my claims and authorizations		
☐ Accessing my medical information		
☐ Other (please specify):		
☐ **ALL OF THE ABOVE**		

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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