

**AUTHORIZATION TO DESIGNATE A PERSONAL REPRESENTATIVE
FOR ALL FAMILY MEMBERS**

| SECTION A: FAMILY MEMBERS REQUESTING A PERSONAL REPRESENTATIVE | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------|----------------|--------------|
| | NAME: (LAST, FIRST MI) | RMSCO ALTERNATE ID OR SS #: (ID # can be found on your ID card) | DATE OF BIRTH: | |
| EMPLOYEE NAME: | | | | |
| SPOUSE NAME: | | | | |
| DEPENDENT NAME: | | | | |
| DEPENDENT NAME: | | | | |
| DEPENDENT NAME: | | | | |
| ADDRESS | | | | PHONE NUMBER |
| | STREET ADDRESS | CITY | STATE | ZIP |
| SECTION B: INDIVIDUAL BEING DESIGNATED AS THE ABOVE FAMILY'S PERSONAL REPRESENTATIVE | | | | |
| PERSONAL REPRESENTATIVE NAME (LAST, FIRST MI): | | | | 4-Digit PIN* |
| | LAST | FIRST | MI | |
| ADDRESS | | | | PHONE NUMBER |
| | STREET ADDRESS | CITY | STATE | ZIP |
| <p align="center"><i>*Note: Your Personal Representative Must Assign a Four-Digit Personal Identification Number. We will require that they identify themselves with this number before we will release Protected Health Information to them.</i></p> | | | | |
| SECTION C: AUTHORIZATION | | | | |
| <p>WE, HEREBY DESIGNATE _____ AS OUR (CHOOSE ONE):</p> <p><input type="checkbox"/> PERSONAL REPRESENTATIVE FOR ALL PROTECTED HEALTH INFORMATION</p> <p><input type="checkbox"/> PERSONAL REPRESENTATIVE FOR ONLY THE FOLLOWING SPECIFIC PROTECTED HEALTH INFORMATION:</p> | | | | |
| SECTION D: EXPIRATION | | | | |
| THIS AUTHORIZATION WILL EXPIRE ON: (COMPLETE ONE) | | <input type="checkbox"/> UPON MY TERMINATION FROM THE HEALTH PLAN <input type="checkbox"/> ON _____ | | |

| | |
|-----------------------------------------------|---------------|
| _____ EMPLOYEE SIGNATURE | _____ DATE |
| _____ SPOUSE SIGNATURE | _____ DATE |
| _____ DEPENDENT SIGNATURE (IF OVER AGE 18) | _____ DATE |
| _____ DEPENDENT SIGNATURE (IF OVER AGE 18) | _____ DATE |
| _____ WITNESS SIGNATURE | _____ DATE |
| _____ PRINT NAME | |

YOU ARE ENTITLED TO A COPY OF THIS FORM

Please print and return this form to the Human Resources office at your employer.