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	

**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.*

Section C: Authorization

We, hereby designate as our (Choose ONE):

Personal Representative for ALL Protected Health Information
Personal Representative For Only The Following Specific Protected health Information:

Section D: Expiration

This Authorization Will Expire On: (Complete ONE)	**Upon my Termination from the Health Plan**
	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		

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