SAN FRANCISCO HEALTH PLAN
Here for you

SAN FRANCISCO HEALTH AUTHORITY
AGREEMENT FOR PERSONAL REPRESENTATIVE FORM

San Francisco Health Plan (SFHP) keeps your health information safe and private.

The information SFHP keeps safe can be about your old or new health information. This information can be about your mental health. (This is called protected health information.)

There is a law about sharing health information. The law protects how your information is shared.

Sign this form to get a Personal Representative. Your Personal Representative can make decisions about your health. Your Personal Representative can share your health information.

Fill out all the information on this form. You will not get a Personal Representative if the form is missing information.

WHAT YOU AGREE TO:

- I agree that I want a Personal Representative. I agree to get a Personal Representative. I agree to sign this form only if I decide to get a Personal Representative.
- My care will not change if I do not want a Personal Representative.
- I can stop using my Personal Representative at any time. To stop using my Personal Representative I need to say this in person or send a letter.
- If I do not sign this form the rules about sharing health information will be different. If I share my own health information, it is not part of the law. The person I share information with can share the information with another person. Another person cannot share my information unless I agree.
- SFHP will not share my health records without my written agreement. This is true even if I have Sensitive Services (a visit or treatment that I want to keep private.)
- I do not need to get approval for Sensitive Services. I do not need approval to submit a claim for Sensitive Services.

  I need to be the age of an adult and able to understand to get Sensitive Services.

  - Sensitive Services can be for mental or behavioral health, sexual and reproductive health, sexually transmitted infections (including HIV and AIDS), alcohol or drug problems, transgender care, and violence from my family or partner.
- I agree to get a Personal Representative during the time I have SFHP benefits.
- SFHP can decide to stop my Personal Representative. SFHP will end my Personal Representative if:
  - My Personal Representative is abusing or hurting me.
  - The choices my Personal Representative makes are bad or put me in danger.
  - SFHP decides it is not good for me to use my Personal Representative.
- I have a right to get a copy of any decisions SFHP makes.

After you sign this form save a copy for you.

Then mail or fax the form to:

San Francisco Health Plan
Attn: Compliance Officer
P.O. Box 194247
San Francisco, CA 94119
Fax: 1(415) 547-7825

INFORMATION

I agree to the use the Personal Representative named below:

My Information:

My Name: _____ My Birth Date: _____

My Address: _____

City, State, Zip: _____ Phone #: _____

Health Plan: _____ ID #: _____

Personal Representative Information:

Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Relationship to Member: _____

WHAT SAN FRANCISCO HEALTH PLAN CAN SHARE WITH YOUR PERSONAL REPRESENTATIVE

I allow San Francisco Health Plan to share the below information. (Check only ONE box.)

☐ I agree to share all my health information with my Personal Representative. This includes many things about my health. This includes a diagnosis (name of illness or condition), claims, doctors and health care providers, and financial information.

This **does not include sensitive (private) information** unless **the boxes are checked below.**

OR

☐ I agree to share only some of my health information. (Check ALL boxes that you agree with.)

- ☐ Grievances and appeals (Legal complaints I make in writing)
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical Records
- ☐ Doctor and Hospital
- ☐ Pre-authorization (treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Pharmacy
- ☐ Other: _____

I also allow San Francisco health Plan to share the private information listed below. (Check ALL boxes that you agree with.)

- ☐ All sensitive (private) information

OR

- ☐ Only information about topics checked below:
  - ☐ Abortion (ending pregnancy)
  - ☐ Abuse (sexual/physical/mental)
  - ☐ Alcohol or drug problems
  - ☐ Behavioral health
  - ☐ Transgender care
  - ☐ Genetic testing
  - ☐ HIV/AIDs
  - ☐ Maternity (pregnancy)
  - ☐ Mental health
  - ☐ Sexually transmitted illness
  - ☐ Other: _____

START AND END DATE OF YOUR PERSONAL REPRESENTATIVE

(Please write "N/A" if you do not want to stop using a Personal Representative on a certain date.)

Don't forget: You can end the use of a Personal Representative at any time.

My Personal Representative starts on _____ and will end on _____.

WHAT I AGREE TO

- ☐ I agree that my Personal Representative can make decisions about a grievance or appeal (legal complaint) including decisions about my rights during a legal process.
- ☐ I agree to let my Personal Representative share my information.
- ☐ Other: _____

SIGNATURES

Date: _____ Time: _____ AM/PM

Signature: _____
(My Information)

Date: _____ Time: _____ AM/PM

Signature: _____
(My Personal Representative)