SAN FRANCISCO HEALTH PLAN
Here for you

SAN FRANCISCO HEALTH AUTHORITY
ASSIGNMENT OF PERSONAL REPRESENTATIVE FORM

Federal law requires San Francisco Health Plan (SFHP) to protect the privacy of information that identifies you and relates to your past, present, and future physical and mental health and conditions ("protected health information").

Completion of this form assigns you a Personal Representative of your choice. Your Personal Representative will be authorized to make health care related decisions or requests on your behalf. Your Personal Representative will be able to use and disclose your protected health information. **Failure to provide *all* information requested may invalidate this authorization.**

NOTICE OF RIGHTS AND OTHER INFORMATION

- I understand that I do not have to complete this form for SFHP unless I want a Personal Representative. Having a Personal Representative is voluntary and I can refuse to sign this.
- SFHP will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization.
- I may cancel this authorization at any time. My revocation may be verbal or in writing. I understand that my revocation of Personal Representative will not apply to any information that has already been released in reliance on this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality laws.
- I understand and agree that this authorization will continue to be valid as long as I am enrolled with SFHP, subject to all other parameters defined in this authorization, including expiration date and my right to revoke this authorization at any time.
- SFHP may elect not to treat the designated individual as my Personal Representative if there is a reasonable belief that: 1) I am subject to domestic violence, abuse, or neglect by that person, 2) treating such person as the Personal Representative could endanger me, or 3) in the exercise of professional judgment SFHP decides it is not in my best interests to treat the designated individual as your Personal Representative.
- I have a right to receive a copy of this authorization upon request.

After signing, please make a copy of this authorization for your records and then mail or fax back to:
San Francisco Health Plan
Attn: Compliance Officer
P.O. Box 194247
San Francisco, CA 94119
Fax: 1(415) 547-7825

DESIGNATION OF PERSONAL REPRESENTATIVE INFORMATION

I hereby designate my Personal Representative as follows:

Member Information:

Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Health Plan: _____ ID #: _____

Personal Representative Information:

Name: _____ Birth Date: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Relationship to Member: _____

This authorization applies to the following protected health information and health care related decisions (select *only* one of the following):

☐ All protected health information and health care decisions pertaining to any medical history, mental or physical condition and treatment received, *including* Acquired Immune Deficiency Syndrome (AIDS) or HIV testing, counseling, and/or treatment, alcohol and/or drug abuse treatment, behavioral or mental health services, and family planning services.

☐ All protected health information and health care decisions pertaining to any medical history, mental or physical condition and treatment received, *except* for Acquired Immune Deficiency Syndrome (AIDS) or HIV testing, counseling, and/or treatment, alcohol and/or drug abuse treatment, behavioral or mental health services, and family planning services.

☐ Only the following types of protected health information and health care decisions (including any dates):

_____

EFFECTIVE DATE

This designation of the Personal Representative becomes effective on _____, and will expire on _____. (*Please write "N/A" if you do not want your Personal Representative's authorization to expire on a set date*. ***Remember: you can always revoke your Personal Representative's authority at any time****.)*

SIGNATURE OF MEMBER AND PERSONAL REPRESENTATIVE

Date: _____ Time: _____ AM/PM

Signature: _____
(Member)

Date: _____ Time: _____ AM/PM

Signature: _____
(Personal Representative)

If you are hearing impaired, please call the TDD/TTY line at **1(415) 547-7830,** toll-free at **1(888) 883-7347** or through the California Relay Service at **711.** You may request this document in alternative formats like Braille, large size print, and audio. To request other formats, or for help with reading this document and other SFHP materials, please call Customer Service at **1(415) 547-7800** or toll-free at **1(800) 288-5555.**