Indiana Health Coverage Programs

PERSONAL REPRESENTATIVE AUTHORIZATION

The individual (member) who is the subject of the health information maintained by the Indiana Health Coverage Programs (IHCP) or the designated personal representative must complete this form. If the personal representative is the only signature, the form must be notarized.

Section A: IHCP Member Information

Name: _____ Phone Number: _____

Address: _____

City, State, ZIP Code: _____

IHCP RID Number: _____ Social Security Number: _____

Designated Personal Representative: _____ Phone Number: _____

Relationship to IHCP Member: _____

Personal Representative Address: _____

City, State, ZIP Code: _____

Specify the dates of personal representative designation. If designation is for an unlimited period, check *Unlimited time period*. If designation is for a limited period, provide the specific dates in the space allowed. **You may revoke this authorization at any time.**

☐ Unlimited time period

Provide specific dates: _____

Section B: Member Signature and Effective Dates

I hereby authorize _____ (name of personal representative) to represent me regarding my rights and responsibilities concerning my protected health care information maintained by the IHCP. This includes, but is not limited to, the right to request and receive copies of my protected health information, request amendment to my health information, request restrictions, and/or authorize the release of my health information. All of these rights are documented in the IHCP *Notice of Privacy Practices* that I have received. **I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the IHCP Privacy Office at the address listed at the bottom of this form**.

Member Signature: _____ Date: _____

(Continued on other side)

Please mail this completed form and supporting documentation, if required, to the following address:

Gainwell - HIPAA
PO Box 50451
Indianapolis, IN 46250-0418

Section C: Personal Representative Agreement and Signature

As the authorized personal representative of _____, I understand that I am representing the above named IHCP member and certify that the information contained herein is true to the best of my knowledge. I also certify that I will only use the above named member's health information for assisting the member with his or her health care.

Personal Representative Signature: _____ Date: _____

Personal Representative Name: _____ Date: _____

If this request is from a personal representative on behalf of the IHCP member who has power of attorney or guardianship rights, please provide a copy of the documentation to support the representation.

This form must be notarized if submitted only with the member's personal representative signature.

Subscribed and sworn (affirmed) before me this _____ day of _____, _____

Signature: _____

Notary Public in and for the state of _____

In the county of _____

(Affix seal)

My commission expires: _____

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IN 46250-0418