Personal Representative Request Form

Member Name: _____
Member ID Number: _____

By completing this form, I am designating the following person / people as my Personal Representative(s). My Personal Representative(s) may discuss any and all information involving my health care management with Central California Alliance for Health. My Personal Representative(s) may exercise my privacy rights and may request records and/or an accounting of disclosures on my behalf. My Personal Representative(s) may also make health care decisions on by behalf, including changing my PCP.

Print Clearly. Use black or blue ink only.

Name (First and Last Name): _____
Relationship: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Other
Phone:_____

Name (First and Last Name): _____
Relationship: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Other
Phone:_____

Name (First and Last Name): _____
Relationship: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Other
Phone:_____

A photocopy/fax of this designation shall be considered as effective and valid as the original. Signed at _____, California, on this ___ day of _____, 20____.
(city) (day) (month) (year)

Your Signature: _____
Signature of witness if you are unable to sign: _____

If you have questions, contact Member Services at 831-430-5505 or 800-700-3874, ext. 5505.