



AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE FORM

Please complete and sign this form to appoint a personal representative. HealthFirst TPA will provide your personal representative the same rights to your confidential information that are provided to you. Please submit this form to the following address:

**HealthFirst TPA
P O Box 130217
Tyler, Texas 75713**

Part A: MEMBER APPOINTING A PERSONAL REPRESENTATIVE

First Name	MI	Last Name
Group number	Birth Date	Telephone #

Part B: YOUR RIGHTS UNDER FEDERAL LAW

You have the right to authorize that the confidential information held by HealthFirst TPA be released to and/or received by persons or organizations you identify. The person or organization you identify below may not be subject to federal health information privacy laws. If this is the case, they may further release your confidential information and federal health information laws may no longer protect it. Upon request, you are entitled to receive a copy of this signed form.

NO CONDITIONS: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

YOUR RIGHTS TO REVOKE: You may revoke this authorization at any time by giving written notice to HealthFirst TPA. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. **Please contact HealthFirst TPA's Customer Service department for more information if you desire to cancel this authorization.**

Part C: AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE

1. Please state the purpose of this authorization:

- To appoint a personal representative to act on my behalf.
- Other: For the following purpose: (Please specify and describe in detail):

2. I hereby authorize the request and release of my confidential information held by HealthFirst TPA to my personal representative. By appointing the person named below as my personal representative, I understand that I am authorizing HealthFirst TPA to give this person access to my confidential information and medical records, the right to talk to HFTPA about my medical care and the right to make decisions that will bind me.

3. I represent that the person named below has agreed to act as my personal representative and that this person is not my court-appointed guardian or my agent under a health care proxy.

4. I understand that my authorization will remain in effect for the length of time specified below.
(Select one of the following):

- a. Until my coverage is cancelled
- b. End Date ____/____/____
- c. Completion of the following activity. Please describe. _____

5. My Personal Representative Information:

Primary First Name	MI	Last Name
My Representative's Relationship to Me		
Address		
City	State	Zip Code
Telephone #	Fax #	
Secondary First Name	MI	Last Name
My Representative's Relationship to Me		
Address		
City	State	Zip Code
Telephone #	Fax #	

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the request and release of my confidential information, as described in this form.

Member Signature: _____ Date: _____



HFTPA Use Only

Date Received:	Received By:	Department:
Date Revoked:	Received By:	Department: