PERSONAL REPRESENTATIVE DESIGNATION

You have the right to request that ALFA Health Plans ("AHP") give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the AHP Privacy Office. You may revoke this designation at any time with written notice to AHP.

MEMBER INFORMATION (REQUIRED) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Social Security #:	Identification #:
Telephone:	E-mail Address:	

PERSONAL REPRESENTATIVE – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Member:
E-mail Address:		

ADDITIONAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Member:
E-mail Address:		

SIGNATURE (REQUIRED)

I request the person(s) named above be allowed access to my protected health information. I understand that I may revoke this designation at any time by submitting a written notice to AHP.

Member Signature **Date**

If the member is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must accompany this form.

Signature of Legal Representative **Relationship to Member** **Date**

In order to process this designation, this form must be complete and signed by the member/legal representative. Incomplete forms will not be accepted.

Return this form to the AHP Privacy Office, P.O. Box 1424, Columbia, TN 38402-1424.

For questions, call the AHP Privacy Office at 1-931-560-0041, ext. 3115 or 6270.

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.