

HIPAA Personal Representative Designation Form

Your privacy is of utmost importance to Peak Health. Please take a moment to complete the form below to designate a Personal Representative to act on your behalf and exercise your rights in discussing, accessing, and disclosing your protected health information (PHI) and benefit coverage with Peak Health as described in the Notice of Privacy Practices. Once this form is completed and returned to Peak Health, your Personal Representative will have access to all records related to the designated representation and will be able to speak on your behalf. All Personal Representative designations may be terminated or revoked at any time in writing or by contacting Member Service at 1-833-5-MYPEAK (1-833-569-7325). Peak Health Member Service will be available Monday through Friday 8:00 a.m. to 5:00 p.m. ET, excluding holidays.

Please complete all required information below

Member Name:	Member ID Number:
Phone Number:	Date of Birth (MM/DD/YYYY):
Address:	
Name of Member's Personal Representative:	Personal Representative's Phone Number:
Personal Representative's Address:	
Please check one of the below to indicate the type(s) of information you would like shared with your Personal Representative(s).	
<input type="checkbox"/> Demographic (address/phone number changes, etc.)	
<input type="checkbox"/> Financial information only (billing records, etc.)	
<input type="checkbox"/> Healthcare information only (health/illness information, HIV/AIDS status, mental health records, coordination of care, complaint resolution, etc.)	
<input type="checkbox"/> All information	
All Representative Designations will remain in effect until the member is no longer active with Peak Health. If you would like the designation to expire sooner, please list expiration date:	

Member Signature: _____ **Date:** _____