



P E R S O N A L R E P R E S E N T A T I V E  
A U T H O R I Z A T I O N

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:  
IHCP Privacy Office  
P.O. Box 50452  
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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