University of Central Arkansas
Designation of Personal Representative Form

UNIVERSITY OF CENTRAL ARKANSAS™

Employee Name: ______________________________

Employee Social Security Number: ________________________________

As an employee of the University of Central Arkansas, I understand HIPAA standards are to protect my medical records and other personal health information. This applies to health plans, health records, and health care providers that conduct certain health care transactions. State and federal law gives me the right to choose one or more persons to act on my behalf with respect to the health information that pertains to me.

I hereby authorize the person(s) indicated below to act on my behalf as my Personal Representative. By authorizing the person(s) below to act as my Personal Representative, I realize that they will be given access to: (check all that apply)

Personal Representative Information:

Name:__________________________
Address: ________________________
City, State, Zip:______________________
Phone Number:_____________________
Email:______________________________
Relationship:_________________________
(Ex. Spouse, mother, father, adult child, sister, brother, etc.)
Date of Birth of Personal Representative:_________________

- ❑ my Protected Health Information
- ❑ my Health Records
- ❑ my Group Insurance Policy Information
- ❑ my Payroll/ Salary Information
- ❑ my Retirement Information

Personal Representative Information:

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Address: ________________________
City, State, Zip:______________________
Phone Number:______________________
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(Ex. Spouse, mother, father, adult child, sister, brother, etc.)
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- ❑ my Health Records
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As the individual who signed this authorization, you have the right to revoke the authorization by completing another Personal Representative form. The later form will supersede the former authorization.

Employee Signature:___________________________________ Date:_____________________