DESIGNATION OF PERSONAL REPRESENTATIVE

You have the right to choose one or more people to act as your personal representative and make decisions about your medical care. Your personal representative will have access to your health information. This includes health records and protected health information that is created by or in the possession of Colorado Access/Access Health Colorado. By choosing a personal representative, you allow Colorado Access/Access Health Colorado to share your health information with your personal representative. You can limit how much health information he/she can see, and you can cancel it at any time. You must include a copy of your member ID card or driver's license with this form, so we can confirm your identity. All references to "member" in this form include a member, client, or beneficiary, as applicable.

- I understand that the rights I am giving to my personal representative will expire on the date that I am no longer a member or one year after the date of my signature below, whichever comes first.
- I understand that my designated personal representative may talk to someone else about my protected health information. My health information cannot be protected if my personal representative tells someone else.
- I understand that I can cancel my choice of personal representative at any time by following the instructions on the second page of this form.
- I understand that if I designate a personal representative, I will not be prevented from getting treatment, payment, enrollment, or eligibility for benefits.
- I understand that this form does not allow the release of any information concerning drug or alcohol abuse, psychological or psychiatric conditions or treatment, psychotherapy notes, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.
- I understand that I can limit the amount of information that my personal representative is given. I limit the access of my personal representative to the following information:

_____

_____

DESIGNATION OF PERSONAL REPRESENTATIVE

I, _____ (print member name) understand all of the information above and choose the following person to act as my personal representative. I am a member of (check one):

☐ Access Behavioral Care ☐ Child Health Plan *Plus* ☐ Access Long Term Support Solutions

☐ Access Health Colorado ☐ Other (specify): _____

_____ _____
Name of Personal Representative | Relationship to Member

_____ _____
Member Signature | Member Date of Birth

_____ _____
Member ID Number or Driver's License Number | Date

ACCEPTANCE BY PERSONAL REPRESENTATIVE

I, _____ (print personal representative name) agree to act as the personal representative for the member listed above. I agree to meet my responsibilities as described in this form on behalf of the member. I agree to keep the information I receive about the member from Colorado Access/Access Health Colorado confidential.

_____ _____
Signature of Personal Representative | DL# or other identification (Used for identity verification only)

_____
Personal Representative Phone

DESIGNATION OF PERSONAL REPRESENTATIVE INSTRUCTIONS

A personal representative is someone you choose to have access to your protected health information. It could be a provider, an advocate, a lawyer, a family member, or any other person you trust.

If you would like to choose a personal representative, you can use this form to name the person you have chosen. You must fill this form out completely and provide all the documentation that is requested. **You must include valid identification, such as a copy of your member ID card, Medicaid or state ID card, or driver's license, so that we can confirm your identity.** You also need to have your personal representative complete and sign the Acceptance by Personal Representative section of the form before you send it to us.

This Designation of Personal Representative Form does not authorize the disclosure or re-disclosure of substance use disorder (drug or alcohol abuse) records, psychological or psychiatric conditions or treatment records, or psychotherapy notes. The disclosure or re-disclosure of these types of records requires a separate consent signed by you or your designated personal representative.

Mail or fax this completed form to:

ABC, CHP+, or RCCO	**Access Health Colorado**	**Access Long Term Support Solutions**
Colorado Access PO Box 17580 Denver, CO 80217-9691	Access Health Colorado PO Box 5846 Denver, CO 80217-9691	Access Long Term Support Solutions PO Box 17767 Denver, CO 80217-7767
Fax: 303-755-4148	Fax: 303-755-4148	Fax: 1-855-744-1723
Phone: 1-800-511-5010	Phone: 1-855-325-9426	Phone: 1-877-710-9993

You can also choose a personal representative in person or by phone. If you have questions or need help filling out this form, call us toll free at the number for your health plan listed above. TTY/TDD users call 1-888-803-4494.

HOW TO CHANGE OR CANCEL YOUR DESIGNATION OF PERSONAL REPRESENTATIVE

If you would like to change or cancel your current designated personal representative, you need to complete a Revocation of Personal Representative Form. Call the appropriate number listed above for more information. TTY/TDD users call 1-888-803-4494.

REVOCATION OF PERSONAL REPRESENTATIVE

You have the right to choose one or more people to act as your personal representative. You also have the right to cancel your choice of personal representative(s) at any time. By canceling your choice of personal representative you are canceling their right to make decisions about your health care. You must include a copy of your member ID card or drivers' license with this form, so we can confirm your identity.

- I understand that by canceling my choice of personal representative Colorado Access/Access Health Colorado will no longer share my health information with them.
- I understand that I have the right to choose another person(s) to act as my personal representative by filling out a new Designation of Personal Representative form.

REVOCATION OF PERSONAL REPRESENTATIVE

I, _____ (print member name), understand all of the information above and choose to cancel the personal representative privileges of the following person:

_____ _____
Name of Personal Representative | Relationship to Member

_____ _____
Member Signature | Member Date of Birth

_____ _____
Member ID Number or Driver's License Number | Date

I am a member of (check one):

☐ Access Behavioral Care ☐ Child Health Plan *Plus* ☐ Access Long Term Support Solutions

☐ Access Health Colorado ☐ Other (specify): _____

REVOCATION OF PERSONAL REPRESENTATIVE INSTRUCTIONS

If you have already chosen a personal representative, you can use this form to cancel your choice of personal representative. You must fill this form out completely and provide all the documentation that is requested. **You must include a copy of your member ID card or driver's license, so that we can confirm your identity.**

Mail of fax this completed form to:

ABC, CHP+, or RCCO	Access Health Colorado	Access Long Term Support Solutions
Colorado Access PO Box 17580 Denver, CO 80217-9691	Access Health Colorado PO Box 5846 Denver, CO 80217-9691	Access Long Term Support Solutions PO Box 17767 Denver, CO 80217-7767
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