Department of Health Care Policy & Financing

DESIGNATION OF PERSONAL REPRESENTATIVE

To allow a family member, other relative, or a close personal friend to have access to protected information.

HIBI Case Number: _____

I _____ (Print name of client), name and appoint _____
(Print name of representative), to serve as my Designated Personal Representative.

I understand that my Designated Personal Representative will have access to information about me that is created by or on behalf of the Colorado Department of Health Care Policy and Financing, and that this information can include Protected Health Information. My Designated Personal Representative is to be provided information about me, on my behalf, in order to assist me as I request of him/her.

I understand that my Designated Personal Representative may disclose my information to a third party, and that the State Department has no control over that additional disclosure and cannot protect the information after it is provided to my Designated Personal Representative.

I understand that I may revoke this Designation at any time by writing to the address below, and that this Designation will remain in effect for 6 years after my death unless I revoke it in writing, or limit it by checking off the box below.

- ☐ This authorization shall expire upon my death.

I understand that my health care treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating a Designated Personal Representative.

I understand that this executed form does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions or treatment or psychotherapy notes, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.

I understand that I may limit the amount of information my Designated Personal Representative is given access to. I choose to limit the access My Designated Personal Representative named above has to the following information: _____

_____

***Please include a copy of client's Medicaid card, a copy of Driver's License, State ID card, or equivalents for both the client and Designated Personal Representative, and any available documentation providing legal authority.

Client Date of birth: ___/___/___ Client signature: _____ Date: ___/___/___

Parent or Legal Guardian may sign on behalf of minor child. Legal Guardian, Power of Attorney or equivalent may *sign on behalf of adult- documentation is required.*

State ID #, Client ID #, **or** Social Security# *(For identity verification purposes):* _____

Designated Personal Representative Information:

Signature: _____ Relationship to client: _____ Phone number: _____

Mailing Address: 1550 Larimer Street, Box# 1000, Denver, CO 80202
Or fax forms to: (855) 226-4424

Phone: (855) MyCOHIBI or (855) 692-6442 | Monday to Friday, 8 a.m. to 5 p.m. Mountain Standard Time
Fax: (855) 226-4424 | Website: www.MyCOHIBI.com | Email: customerservice@MyCOHIBI.com

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