Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

DATE Case Number :

POLICYHOLDER NAME
MAILING ADDRESS
CITY, ST ZIP

Designation for Personal Representative Form Request- Please Review and Return.

Policy Holder:

Dear POLICYHOLDER NAME,

A dependent on your policy is over the age of 18 or turning 18. In order to protect the privacy of the dependent's health care information and to allow a family member, other relative or personal friend to have access to protected information and act as their Designated Personal Representative, please have the dependent complete and sign the attached form. Be sure to return the form with a copy of the Medicaid card, A copy of a Driver's License, a State ID card, or equivalents for both the client and the Designated Personal Representative, and any available documentation providing legal authority.

Submit all documents to Colorado HIBI by fax or USPS

- Fax:(855)226-4424
- Mail:Colorado HIBI Program
  5615 High Point Dr
  Irving, TX 75038

Thank you in advance for your time and considerations. If you have any questions or concerns, please call our office at (855) MyCOHIBI(855-692-6442) or email: COHIBICustomerService@GainwellTechnologies.com
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Sincerely,

The HIBI Team

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: 5615 High Point Dr, Irving, TX 75038
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: COHIBICustomerService@GainwellTechnologies.com