



# Personal Representative Request Form



Member Name: \_\_\_\_\_  
Member ID Number: \_\_\_\_\_

By completing this form, I am designating the following person / people as my Personal Representative(s). My Personal Representative(s) may discuss any and all information involving my health care management with Central California Alliance for Health. My Personal Representative(s) may exercise my privacy rights and may request records and/or an accounting of disclosures on my behalf. My Personal Representative(s) may also make health care decisions on my behalf, including changing my PCP.

**Print Clearly. Use black or blue ink only.**

Name (First and Last Name): \_\_\_\_\_  
Relationship: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Other  
Phone: \_\_\_\_\_

Name (First and Last Name): \_\_\_\_\_  
Relationship: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Other  
Phone: \_\_\_\_\_

Name (First and Last Name): \_\_\_\_\_  
Relationship: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Other  
Phone: \_\_\_\_\_

A photocopy/fax of this designation shall be considered as effective and valid as the original. Signed at \_\_\_\_\_, California, on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(city) (day) (month) (year)

Your Signature: \_\_\_\_\_  
Signature of witness if you are unable to sign: \_\_\_\_\_

If you have questions, contact Member Services at 831-430-5505 or 800-700-3874, ext. 5505.