SUFFOLK COUNTY
EMPLOYEE MEDICAL HEALTH PLAN ("EMHP")
HIPAA DESIGNATION OF
PERSONAL REPRESENTATIVE FORM

Employee/Retiree/Dependent's Name: _____

Social Security Number (last four digits): _XXX-XX-_____

Suffolk County Employee/Retiree's Name:_____

Suffolk County Employee/Retiree's Social Security Number (last four digits):_XXX-XX-_____

I, _____, permit the Employee Benefits Unit of the S.C. Department of
(name of Employee/Retiree/Dependent)

Civil Service to discuss any of my health information to the following individual(s) on my behalf, including eligibility for health benefits and claims payments or any other health benefits issues with the following individual(s):

_____

(Name of Personal Representative)

_____

(Name of Personal Representative)

I understand that if I ever wish to revoke the right of a personal representative to obtain my eligibility or health benefits information on my behalf, I must notify the Employee Benefits Unit of the S.C. Department of Civil Service, in writing that the individual(s) is/are no longer my personal representative.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature of Employee/Retiree/Dependent Date