MASSACHUSETTS

Member's Designation of a Personal Representative

Please use this form to authorize Blue Cross and Blue Shield of Massachusetts, Inc. to provide the Personal Representative named with unlimited access to the Member's information.

The member named below should be the person signing this designation and consenting to the release of information. If the member is a minor, a parent or legal guardian must sign. If the member is unable to sign for any other reason, a legal representative must sign the designation and submit documentation to verify the authority to sign.

Member's Name: _____

Member's ID#: _____ Date of Birth: _____

Address: _____ Daytime Phone Number: _____

The following individual is designated to act as Personal Representative:

Name: _____

Address: _____ Daytime Phone Number: _____

Scope of Designation. The individual named as my Personal Representative may act on my behalf in regard to health care coverage provided to me through Blue Cross. Blue Cross may respond to questions from my Personal Representative on my behalf and disclose information to my Personal Representative in the same manner and to the same extent that Blue Cross would disclose information to me. This includes any and all claims, medical records, and information relating to me (including, but not limited to, records related to HIV Testing, AIDS diagnosis or treatment, and mental health). I understand that Blue Cross will send benefit payments due me and written communications regarding my coverage in accordance with Blue Cross' standard practices, unless I have specified otherwise in writing.

This designation is valid until I revoke it. I may revoke this designation at any time by notifying Blue Cross in writing. I understand that a revocation will not apply to information that was already released while this designation was in effect. I understand that once information has been released according to these instructions, Blue Cross will not be able to limit the recipient's use or disclosure of the information, and privacy laws may no longer protect the information. I may receive a copy of this designation and agree that a photocopy is as valid as the original.

Signature: _____ Print name: _____ Date: _____

If not the member, please state your relationship to the member (for example, "parent") here: _____

Please return this form to:
Blue Cross and Blue Shield of Massachusetts, P.O. Box 986030, Boston, MA 02298, Attn: System Security Requests