BlueCross BlueShield | FEP Vision℠

Personal Representative Designation

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required. *(Please Print)*

Person Granting Authorization	Policy Holder Information
Date: _____	**ID Number:** _____
Name: _____	**Name:** _____
Address: _____	**Address:** _____
_____	_____
Date of Birth: _____	**Telephone:** _____

I hereby designate the individual(s) noted below as my Personal Representative and authorize and direct Blue Cross Blue Shield FEP Vision℠ and its affiliates to furnish and release vision care insurance information regarding the person noted above.

Personal Representative(s):

Name: _____
Street Address: _____
City, State, Zip: _____

Name: _____
Street Address: _____
City, State, Zip: _____

My protected health information is information about me, including information such as my name and address and/or medical information. The information was used or created when I received vision care or when payment was received for my vision care. The information may include my past, present or future vision health care or condition.

I understand that if the person I designate as my Personal Representative is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Mail or fax this completed form to:

BCBS FEP Vision℠ Privacy Office
P.O. Box 1416
Latham, NY 12110-1416
Fax: 1-866-999-4640

If you have questions, need additional information or assistance in completing your request, please contact the BCBS FEP Vision℠ Privacy Office at 1-800-571-3366 or the address shown above.

You must indicate a date or event that will trigger the expiration of this Personal Representative Designation. Upon expiration, the person designated as your personal representative will not longer be able to receive your information.

Expiration:	This Personal Representative Designation will expire on ____/____/____ or on occurrence of the following event: _____
Right to Revoke:	This Personal Representative Designation may be revoked at any time. Contact BCBS FEP Vision℠ Privacy Contact Office at 1-800-571-3366 for further instructions. Revocation of this authorization will not affect any action taken before Davis Vision, Inc. receives the notice of revocation.

Signature: _____ **Date:** _____

If the Personal Representative Designation is a result of a Power of Attorney or other Court Initiated document, please attach the document(s).

PLEASE RETAIN A COPY OF THIS SIGNED DESIGNATION FOR YOUR RECORDS