

The privacy of your child or the child or your care is important to us. UPMC *for Kids*[™] will only talk to the person listed as the Head of Household on your Children's Health Insurance Program (CHIP) application. We can only talk to someone else about your child if you give us your written permission. We have received your request to have a personal representative, who is another person that can act on your behalf. This person can talk with us about your child's health information and the benefits your child has through UPMC *for Kids*[™]. For us to talk with this person, we need you to complete this form and return it to us at:

UPMC *for Kids*[™]
P.O. Box 2965
Pittsburgh, Pennsylvania 15230-2965
Or fax to us at 412-454-7829

Once we receive this completed form, we will verify your request. Then we will note in our records that you have given approval to UPMC *for Kids*[™] to talk to the person you listed on this form. At that time we can begin speaking to this person. You can put more than one child who is a member of UPMC *for Kids*[™] on this form if they have the same personal representative. If the personal representative is different, please complete two forms. Fill out all the sections below. You must print or type the information; if printing, please use a pen. Note: the UPMC *for Kids*[™] ID number is on the front of the child's ID card.

Child's first name:	Last name:	UPMC <i>for Kids</i> [™] ID #:	Date of birth:
Child's first name:	Last name:	UPMC <i>for Kids</i> [™] ID #:	Date of birth:
Child's first name:	Last name:	UPMC <i>for Kids</i> [™] ID #:	Date of birth:
Address:		Best phone number to reach you if we have questions:	
Name of person you approve to be a personal representative for the child(ren) listed above: First name: Last name:		Relationship to child(ren):	
Address of personal representative:		Phone number of personal representative:	
Do you want to set any limitations on what the personal representative may discuss with UPMC <i>for Kids</i> [™] ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify what we can discuss, for example, payment of health care bills, medications prescribed by the doctor, or help with scheduling doctor visits.			
Do you want this approval to continue without a time limit? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please list the date you want your approval to end. _____			

Head of Household Name: (Print) _____

Signature _____ Date _____

Personal Representative Name: (Print) _____

Signature _____ Date _____

If you have any questions about this Personal Representative Designation Form, please call the Member Services Department at 1-800-650-8762. TTY users call 1-800-361-2629.