Group Health Cooperative
of South Central Wisconsin

Personal Representative Form

Incomplete or illegible forms will not be processed.

Purpose: The purpose of this form is to provide the GHC-SCW patient with the opportunity to exercise his/her right to designate another adult to serve as personal representative. The personal representative has the rights and responsibilities described below regarding my care, treatment, insurance and other functions as described below.

Patient Information

Patient Name (Please print) ____________________ GHC# __________ DOB __________

Street Address ____________________ City __________ State ______ Zip ______

E-Mail Address (providing address denotes permission to use) ____________________ Phone Number __________

Personal Representative Information

Personal Representative Name (Please Print) ____________________ Relationship to Patient __________ Phone Number __________

Street Address ____________________ City __________ State ______ Zip ______

I authorize my personal representative:

__ Complete permission to act on my behalf regarding all treatment, payment & health care operations

__ Permission to interact regarding health care only

__ Permission to interact regarding insurance, benefits, referrals, etc.

__ Other (describe):____

Signature

I hereby assign the individual noted above as my personal representative. I have read and understand this information, I am signing this form voluntarily and understand that I may revoke it at any time.

Signature of Patient ____________________ Date of Signature __________

Upon completion of form, return to the GHC-SCW Privacy Officer using one of these options:

USPS Mail
GHC-SCW
Privacy Officer
1265 John Q. Hammons Drive
Madison, WI 53711

Fax
(608) 662-4965

PDF as E-Mail Attachment
privacy@ghcscw.com