PROSPECT MEDICAL
Quality Service ~ Quality Care

600 City Parkway West, Suite 800
Orange, CA 92868
(800) 708-3230 or (714) 796-5900
ProspectMedical.com

DESIGNATION OF PERSONAL REPRESENTATIVE FORM

Please provide member's information below:

Last Name:_____First Name:_____Middle Initial: ___

Street Address:_____Apt#__

City:_____State:_____Zip:_____

Home Telephone:_____Work Telephone:_____

Date of Birth:_____Health Plan:_____

Health Plan Identification Number:_____

I, _____, the undersigned, hereby authorize
Member Name

_____.
Designated Representative's Name

To be my personal representative and request that Prospect Medical treat the named individual as my Health Plan would otherwise treat me regarding my protected health information. I understand that this form is voluntary. I understand that federal privacy laws will no longer protect the released information when the person(s) designated as my personal representative receives this information.

Signature:_____Date:_____
Member Signature required here

Customer Service Department
Prospect Medical Systems
Telephone: (800) 708-3230
Fax: (714) 560-5252