TEXAS FARM BUREAU® HEALTH PLANS
INSURED BY MEMBERS HEALTH INSURANCE COMPANY

PERSONAL REPRESENTATIVE DESIGNATION

You have the right to request that Texas Farm Bureau Health Plans, insured by Members Health Insurance Company ("TFBHP"), give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the TFBHP Privacy Office. You may revoke this designation at any time with written notice to TFBHP.

INSURED INFORMATION (REQUIRED) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Social Security #:	Identification #:
Telephone:	E-mail Address:	

PERSONAL REPRESENTATIVE – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Insured:

ADDITIONAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT		
First Name:	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Telephone:	Relationship to Insured:

SIGNATURE (REQUIRED)

I request the person(s) named above be allowed access to my protected health information. I understand that I may revoke this designation at any time by submitting a written notice to TFBHP.

Insured Signature **Date**

If the member is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must accompany this form.

Signature of Legal Representative **Relationship to Insured** **Date**

In order to process this designation, this form must be complete and signed by the insured. Incomplete forms will not be accepted. **Return this form to the TFBHP Privacy Office, P.O. Box 1424, Columbia, TN 38402-1424.**

For questions, call the TFBHP Privacy Office at 1-888-708-0123

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.