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Med-Pay, Inc.

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PERSONAL REPRESENTATIVE WITH UNLIMITED AUTHORITY TO ACCESS PROTECTED HEALTH INFORMATION ON BEHALF OF MINOR CHILD

For the purpose of assisting me in the management of my child's health care coverage, services, treatment, and bills, this form identifies the personal representative I am authorizing to act on my behalf and that of my child to access any and all medical information and records from health care providers, claims administrators and/or other entities.

This authorization applies to my child's private health information (PHI), including, but not limited to: eligibility, claims status, payment status, and any and all medical information and records. This form is to identify the representative I am authorizing to act on my child's behalf, as the participant, to access any and all medical information and records for the purpose of assisting me in the management of my child's health. Unless otherwise cancelled by me, this unlimited access authorization will continue for a period of one (1) year from the date it is signed.

Individual Making Request, if different from Participant/Child: _____

Relationship of Requestor to Participant/Child:_____ SSN: _____

Child's Name: _____ SSN: _____

Child's Address: _____

Child's Date of Birth: _____ Group Number: _____

Type of PHI to which to this authorization applies: eligibility, healthcare claims status, payment status, and any and all medical information and records, including those that may be available via on-line access through my health care plan.

On behalf of the minor child, as that child's parent and/or authorized legal representative, I designate _____ , whose relationship with this child is _____, and whose social security number is _____, as a personal representative with unlimited authority to access any and all medical records and information as they pertain to the management, treatment and care of this child's illness.

I can cancel this form at any time by informing Med-Pay, in writing. But, I understand that if any of my child's records or information has already been released because this form was signed, I can't cancel those releases of records or information.

A copy of this original shall serve the same purpose as the original.

_____ _____
Signature of Participant or Legal Representative Date

WITNESS NAME (printed) & SIGNATURE _____
(Cannot be any individual identified above.)

FOR INTERNAL USE ONLY: Date Received: _____
Identity of Participant and/or Legal Representative Obtained/Filed: _____Yes _____No
Associate Processing this Request: _____ _____
Name/Date Name/Date

Date Authorization *Removed* by Participant or Legal Representative: _____ (Attach Completed Removal Request Form)
Identity of Participant and/or Legal Representative Obtained/Filed: _____Yes _____No
Associate Processing this Request: _____ _____
Name/Date Name/Date