

APPOINTMENT OF PERSONAL REPRESENTATIVE

My name

I am an Eligible Individual of Philadelphia County Funded DBHIDS Services.

My address

My date of birth

My social security number

I would like

to be my Personal Representative for the purpose of the complaint that I have filed or will be filing.
This means that they will be acting on my behalf during the complaint process.

The complaint was filed, or will be filed, on Date

The following is a short description of what my complaint, grievance, or fair hearing is about

I understand that because my Personal Representative will be acting for me, he or she will receive confidential information about me. This information could include any evaluations and records of any treatment that I have received. This is called Protected Health Information (PHI) under the federal law called the Health Insurance Portability and Accountability Act (HIPAA). My PHI is also confidential under the Pennsylvania Mental Health Procedures Act.

I give DBHIDS permission to give my Personal Representative any of my PHI that is needed for this complaint.

This form will allow my personal representative to act for me only for this complaint. If for any reason the complaint is not decided within 365 days, I will have to sign a new form if I want to keep my personal representative.

Signature of Eligible Individual

Date

Signature of Personal Representative

Date

Personal Representative's address

Personal Representative's telephone number

You can revoke the rights of your Personal Representative at any time by informing DBHIDS Quality Management by
Phone: **215-685-5458**

Fax: **215-685-4649**

Email: DBHIDS.Complaints@phila.gov

Mail: **DBHIDS, Quality Management, DBHIDS Complaints**
1101 Market Street, 7th Floor, Phila., PA 19107-2907