AMERICAN SAMOA MEDICAID STATE AGENCY
OFFICE OF THE GOVERNOR
AMERICAN SAMOA 96799

Personal Representative Request Form

Important Information about Personal Representatives

The HIPAA Privacy Rule requires the American Samoa Medicaid State Agency to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care. The purpose of appointing a Personal Representative is to enable another individual to act on your behalf with respect to: (1) making decisions about your health care and treatment while in NZ; (2) discussing with our office anything related to your medical referral to NZ (3) requesting and/or disclosing your PHI; and (4) exercising some or all your rights you have under Medicaid and its NZ medical providers.

You have the right to authorize that the PHI held by the American Samoa Medicaid State Agency be released to and/or received by persons or organizations you identify. The person or organization you identify on the Personal Representative Request Form may not be subject to the HIPAA Privacy Rule. If this is the case, your appointed Personal Representative may further release your confidential information without protection from federal or state privacy laws.

Appointing a Personal Representative is voluntary.

The American Samoa Medicaid State Agency will not treat someone as your Personal Representative if (1) we reasonably believe you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgment, we decide that it is not in your best interest to treat the person as your Personal Representative.

To assist the American Samoa Medicaid State Agency in responding to your request to appoint a Personal Representative, please complete the following form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your personal representative's legal authority to act on behalf in decisions related to health care. If you are giving permission to the American Samoa Medicaid State Agency to share the PHI of your minor child, please complete the applicable section of the form below.

Please email the completed form to the American Samoa Medicaid State Agency at omr@medicaid.as.gov

Or

Submit the completed application to our office which is located on the 3rd floor Suite 306 at the ASTCA Executive Building in Tafuna. If you have any questions about this form, please call the American Samoa Medicaid State Agency staff member at (684) 699-4777 or 699-4778.

Sincerely,

The Medicaid OMRNZ Staff

OFFICE OF THE GOVERNOR
AMERICAN SAMOA MEDICAID STATE AGENCY
AMERICAN SAMOA 96799

[Please Print]

DESIGNATED PERSONAL REPRESENTATIVE FORM

This form identifies a person authorized by the patient to act on a patient's behalf in making decisions related to the patient's support and healthcare for purposes of the Medicaid OMRNZ program. This provision applies to a person with legal guardianship, power of attorney, or other documented legal authority to act on behalf of a member. This designation should not be considered a general Power of Attorney.

Individual Appointing a Personal Representative

Name (First, Middle, Last, Title)	Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female
Address or Village	Home Telephone	
Type of Identification Provided ☐ Driver's License ☐ Social Security ☐ Birth Certificate ☐ Other	Identification Number	

Identification of Personal Representative

Name (First, Middle, Last, Title)	Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female
Address or Village	Personal Representative's Relationship to Me	

Granting Access to PHI of Minor Child to Another Person

Name of Personal Representative (First, Middle, Last, Title)	Home Telephone	
Address or Village	Personal Representative's Relationship to Children	
Child's Name (First, Middle, Last, Title)	Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

Authorization to Appoint a Personal Representative

1. Please state the purpose of this authorization
   - ☐ To appoint a personal representative to act on my and/or my minor children's behalf for decisions related to health care.
   - ☐ Other: For the following purpose please specify and describe below

2. I hereby authorize the request and release of PHI held by the American Samoa Medicaid State Agency to the above personal representative. By appointing the person name on this form as a personal representative, I understand that I am authorizing the American Samoa Medicaid State Agency to give this person access to PHI, the right to talk to Medicaid about medical care, and the right to make decisions that will bind me.
3. I represent that the person I am appointing has agreed to act as my and/or my minor child's personal representative.
4. I understand that my Personal Representative designation remains in effect until a court order, an applicable law, or I revoke it.

Patient Signature	Personal Representative Signature
Date Signed	Date Signed

IMPORTANT MESSAGE: The appointment of a personal representative is only valid for the duration of the patient medical referral process and treatment under the Medicaid OMRNZ program. You may revoke the appointment at any time in writing and may submit it to us either email at omr@medicaid.as.gov or at our office in Tafuna.