APPOINTMENT OF PERSONAL REPRESENTATIVE FOR ACCESS TO PHI UNDER HIPAA

HIPAA Privacy Policy Form – For PHI Related to MPC Benefit Plans

Please complete and sign this form to appoint a personal representative under the MPC benefit plans. MPC will provide your appointed personal representative the same rights to your Protected Health Information (PHI) that are provided to you. **Questions regarding this form should be directed to the HIPAA Privacy Officer at 419-422-2121 or privacy@marathonpetroleum.com.**

MEMBER APPOINTING A PERSONAL REPRESENTATIVE:

Member Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	SSN or Employee ID#:
Address (Street, City, State, Zip):	Home Telephone (+ Area Code):	

INFORMATION ABOUT THE PERSONAL REPRESENTATIVE WHO WILL HAVE ACCESS TO YOUR PERSONAL HEALTH INFORMATION:

Name (First, Middle, Last, Title):	Home Telephone (+ Area Code):
Address (Street, City, State, Zip):	Personal Representative's Relationship to Me:

IF YOU ARE GRANTING ACCESS TO PHI OF COVERED MINOR CHILD TO ANOTHER PERSON:

Name of person to whom you are granting this access (First, Middle, Last, Title):	Home Telephone (+ Area Code):	
Address (Street, City, State, Zip):	Personal Representative's Relationship to the Children:	
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:

PURPOSE OF THIS AUTHORIZATION:

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 in detail):

_____
_____
_____
_____

This authorization applies to the following Plans *(check all that apply)*:

___ Health Plan ___ Retiree Health Plan ___ Employee Assistance Program

___ Dental Plan ___ Pre-65 Retiree Dental Plan

___ Vision Plan ___ Pre-65 Retiree Vision Plan ___ Exchange Health Reimbursement Account Plan

___ Health Care Flexible Spending Account Plan

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AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE:	
1. I hereby authorize the request and release of PHI to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing MPC to give this person access to PHI, the right to talk to MPC about medical care, and the right to make decisions that will bind me. 2. I represent that the person I am appointing has agreed to act as my and /or my minor children's personal representative. 3. I understand that my Personal Representative designation remains in effect until a court order, an applicable law, or I revoke it.	
Member Signature:	Personal Representative Signature:
Date Signed:	Date Signed:
Witnessed by:	Date Signed:

Return completed form to:

MPC Benefits
Attn: HIPAA Privacy Officer
539 South Main Street
Findlay, OH 45840
privacy@marathonpetroleum.com

Determining whether an individual should be treated as a personal representative is made under applicable state law. Requests to name a Personal Representative will be reviewed under the applicable state laws governing powers of attorney and, specifically, health care powers of attorney, and may require notarization. Requests will be reviewed and approved as received.

Privacy Officer Comments:

___ Accept this request.

___ Reject this request. Reason:_____

___ Individual contacted.