IOWA Health and Human Services

Designation of Personal Representative

Name of Client		Date of Request
Mailing Address – Street or P.O. Box		State ID
City, State, and Zip Code	Phone Number	Date of Birth

Check all the programs that apply:

- ☐ Medicaid
- ☐ Hawki
- ☐ Woodward Resource Center
- ☐ Cherokee Mental Health Institute
- ☐ Independence Mental Health Institute

To be completed by client

I hereby designate the following individual as my personal representative:

Name of Personal Representative	Relationship to Client (e.g., child, spouse, friend, attorney)
Mailing Address – Street or P.O. Box	Phone Number
City, State, and Zip Code	Email Address of Individual Representative

Information to be shared:

- ☐ Mental health information
- ☐ Alcohol, drug, or substance use disorder information
- ☐ AIDS, HIV-related information
- ☐ All my health information
- ☐ Financial information (billing records)
- ☐ Other _____

Client's Signature	Date