



## Limited Health Care Power of Attorney

I, \_\_\_\_\_, do name and appoint  
Member Name

\_\_\_\_\_ to act on my behalf with respect to all  
Designee's Name

business and health care transactions with Peoples Health including, without limitation, those involving health care decisions, medical expenses, changing my address, authorizing the use and disclosure of my protected health information, filing appeals and grievances on my behalf, and enrollment and disenrollment from Peoples Health. I understand that I may revoke this Limited Health Care Power of Attorney at any time by notifying Peoples Health verbally or in writing. A photocopy or facsimile copy of this Limited Health Care Power of Attorney shall be considered as valid and binding as an original. I have read and fully understand this Limited Health Care Power of Attorney.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Member Number: \_\_\_\_\_