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Designation of Personal Representative

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization, you are informing us of your designation of the named person as your personal representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

Patient Name: _____ Date of Birth: _____

Personal Representative Information:

Designated Representative Full Name: _____ Date of Birth: _____

Representative's relationship to patient: _____ Last 4 SS#: _____

Driver's License or Personal ID# _____

Representative's Contact Phone Numbers: _____

- The chosen personal representative will, at all times, be required to verify identity by providing their personal ID# or last four of their SS# as written above.

I, the undersigned, understand that I have the right to refuse to designate a personal representative. I have the right to revoke this designation in writing at any time. I further understand that such revocation does not apply to the extent that persons who have been authorized by my personal representative to use or disclose my health information have already acted in reliance on said designation.

Patient Signature: _____ Date: _____

Witness Signature: _____