THE FAMILY DOCTORS
Designation of Personal Representative (For Use/Disclosure of Health Information Only)

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. This form indicates your desire to designate the listed individual(s) to be your personal representative for your health information. Your designation can be revoked at any time.

DESIGNATION

I, the undersigned, hereby designate the following person to act as my personal representative with respect to decisions regarding the use and/or disclosure of my health information.

______________________________ ______________________________
Representative's Name (Please print) Relationship to you

This person shall be given all of the privileges that would belong to me regarding my health information.

I understand that I may revoke this designation at any time by signing a revocation and delivering it to The Family Doctors. I further understand that any revocation will not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on my previous designation.

______________________________ ______________________________
Patient's Name (Please Print) Date

____
Patient's Signature

REVOCATION SECTION

I hereby revoke my designation of a personal representative.

______________________________ ______________________________
Patient's Name (Please Print) Date

____
Patient's Signature

Confidential Communication Request

If you would like for The Family Doctors to contact you with your health information at an alternate phone number or address, please list this information below:

Mailing Address: ____
City: ______________________________ State: __________ Zip Code: __________

Daytime Telephone #: ___________________ Evening Telephone #: ____________________