the Family Doctors
West Jefferson Medical Center

Designation of Personal Representative

Please use this form to designate a personal representative to act on your behalf in making healthcare related decisions and unlimited access to the patient's information.

The patient named below should be the person signing this designation and consenting to the release of information. If the patient is a minor, a parent or legal guardian must sign. If the patient is unable to sign for any other reason, a legal representative must sign the designation and submit documentation to verify the authority to sign.

Patient's Name _____ Date of Birth _____

Address _____

Home Phone _____ Work Phone _____

I hereby designate the following individual(s) as my personal representative:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please read each of the following statements carefully before signing this document.

- I understand that this designation will not expire unless I indicate an expiration date or I revoke it.
  Date to expire: _____
- I understand that this designation is voluntary and being made at my request.
- I understand that the released information may no longer be protected by federal privacy laws and may be rediclosed by the individual that receives the information.
- I understand that I may revoke this *Designation of Personal Representative* at any time by sending a written notification to my doctor's office, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that my health plan has already used or disclosed, relying on this designation.

I may receive a copy of this designation and agree that a photocopy is as valid as the original.

Signature _____ Date _____