# DESIGNATION OF PERSONAL REPRESENTATIVE



Dear Patient:

Personal representatives are people who you have given permission to speak for you when you receive healthcare related services. This may be a family member, a neighbor, or a friend. Without a signed authorization form that grants your permission, our office will not be allowed to talk or release any information to anyone other than yourself. If you are going to ask someone to make calls on your behalf, then a signed authorization form will need to be on file. You may ask for our form or you may have a more formal legal document in place.

Thank you in advance for your cooperation and for choosing the Family Doctors. If you have any questions regarding our office policies, please contact us and we will be happy to assist you. We look forward to working in partnership with you to meet your healthcare needs.

Sincerely,

Your Family Doctors Physicians and Staff

| West Jefferson Medical Center<br>LCMC Health | **DESIGNATION OF PERSONAL REPRESENTATIVE**<br>PAGE 1 OF 1 | *PATIENT INFORMATION*<br>*PLACE PATIENT'S LABEL HERE* |
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Please use this form to designate a personal representative to act on your behalf in making health care 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.

- o I understand that this designation will not expire unless I indicate an expiration date or I revoke it. Date to expire: _____
- o I understand that this designation is voluntary and being made at my request.
- o I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual that receives the information.
- o I understand that I may revoke this *Designation of Personal Representative* at any time by sending a written notification to your 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:**<br>**X** | **Date** MM/DD/YY<br>/ / | **Time** 00:00 AM/PM<br>: |
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