Patient Name: _____
Patient DOB: _____

Our Lady of the Lake Physician Group
Lourdes Physician Group
St. Francis Medical Group

PERSONAL REPRESENTATIVE DESIGNATION FORM

The Health Insurance Portability and Accountability Act of 1996 gives you the right to have one or more persons act as your representative to make decisions about the uses and sharing of health information about you. This form tells us that you have named this person as your authorized personal representative. You can limit the amount of information that the authorized personal representative can decide about, and you can cancel this at any time.

DESIGNATION SECTION

I, _____, hereby name the following person(s) to act as my authorized personal representative(s) with respect to decisions involving the use of and/or the sharing of health information that pertains to me.

Name: _____ **Name:** _____
Last First MI *Last First MI*

Relationship to Patient: _____ **Relationship to Patient:** _____

Mailing Address: _____ **Mailing Address:** _____

City/State/Zip: _____ **City/State/Zip:** _____

Primary Phone: _____ **Primary Phone:** _____

Please provide a password or other unique identifier that your personal representative(s) must provide during phone inquiries (example: last four digits of your SSN). _____

INFORMATION PERMISSIONS

Please check one of the below to indicate the type(s) of information you would like shared with your personal representative(s).

- ❑ Financial and demographic information only (billing records, address/phone number changes, etc.)
- ❑ Healthcare information only (health/illness information, HIV/AIDS status, mental health records, coordination of care, compliant resolution, etc.)
- ❑ Financial, demographic and health information
- ❑ Other: _____

Patient Name: _____
Patient DOB: _____

I understand that I may cancel this designation at any time by signing the revocation section of my copy of this form and returning it to my healthcare provider.

I understand that any cancellation can only apply to future disclosures or actions regarding my health information and cannot cancel actions taken or disclosures made while the designation was in effect.

The expiration date for this designation, if no date is specified, is 365 days following the date below.

Patient Name (print): _____

Patient Signature: _____

Date: _____ **Time:** _____

REVOCATION

I no longer want the personal representative(s) listed on this form to act as my personal representative(s).

Patient Name (print): _____

Patient Signature: _____

Date: _____ **Time:** _____