BROC
BATON ROUGE ORTHOPAEDIC CLINIC

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_____

Relationship to Patient_____ Relationship to Patient_____

Mailing Address_____ Mailing Address_____

City/State/Zip_____ City/State/Zip_____

Primary Phone_____ Primary Phone_____

Personal Representative(s) will need to provide the patient's last name and last four digits of the patient's social security number when acting on the patient's behalf.

INFORMATION PERMISIONS

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, coordination of care, etc.)

☐ Financial, demographic and health information

☐ Other _____

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 on my behalf.

Patient Name (Print)_____

Patient Signature_____

Date_____ Time_____