PATIENT REPRESENTATIVE DESIGNATION FORM

As required by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, you have the right to designate a person to act on your behalf with respect to your protected health information (PHI).

A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient directly. Such information could include appointment changes, messages regarding care, physician responses, and/or medication requests. A Families First Pediatrics staff member may refuse to disclose information to a person identified as a patient's personal representative if that staff member believes such information should be given directly to the patient.

PLEASE NOTE: *This form does NOT grant permission to release medical records to any designated representatives or for the designated representative to authorize any release of medical records.*

PATIENT INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT PHONE: _____

PERSONAL REPRESENTATIVE #1

DESIGNEE FULL NAME: _____ DESIGNEE DATE OF BIRTH: _____

RELATION TO PATIENT/FAMILY: _____ DESIGNEE PHONE #: _____

☐ **Financial Information Only**

☐ **Medical Information Only**

☐ **Both Medical and Financial Information:**

☐ **INCLUDE PROXY PORTAL ACCESS: Designee Email Address: _____**

PERSONAL REPRESENTATIVE #2

DESIGNEE FULL NAME: _____ DESIGNEE DATE OF BIRTH: _____

RELATION TO PATIENT/FAMILY: _____ DESIGNEE PHONE #: _____

☐ **Financial Information Only**

☐ **Medical Information Only**

☐ **Both Medical and Financial Information:**

☐ **INCLUDE PROXY PORTAL ACCESS: Designee Email Address: _____**

By signing this form, I agree and understand that I may revoke or terminate this authorization at any time by submitting a written revocation to Families First Pediatrics. I understand that provisions will otherwise remain in effect for 365 days from the date of authorization and will need to provide any additional provisions of personal representation beyond expiration of this authorization.

Patient's Signature: _____ Date: _____/_____/_____

Patient's Name (please print): _____ DOB: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____