



DESIGNATION OF PERSONAL REPRESENTATIVE

Name: _____

Date: _____

DOB: _____

Source: _____

Account No.: _____

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: _____

Address: _____

Telephone: _____ Cell: _____

What relationship is this person to you? _____

This person is to be afforded all of the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:

Medical Records
North County OB-GYN Medical Group, Inc.
9850 Genesee Avenue, Suite 600
La Jolla, CA 92073

I further understand that any such revocation does not apply if that person or persons authorized to use or disclose my protected health information have already taken action on my behalf.

Date

Patient's Signature

REVOCACTION SECTION:

I hereby revoke this designation of a personal representative.

Date

Patient's Signature