Johnson Memorial Health Physician Network Orthopedics and Sports Medicine

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), 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 or your child. By completing this form, you are informing us that you wish to designate the named person(s) as you or your child's 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.

Patient Name:_______________________________________ Date of Birth: _____/_____/_____
(Print Name)

Designation:

I, ___________________________ (print name), hereby nominate the following person(s) to act as my or my child's personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me or my child.

Please check the applicable box indicating if we may discuss your or your child's health status or financial (bill) matters with your selection(s) below.			Health Status	Financial
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No

By signing this document, I acknowledge that I have read and understand this General Information and Consent. I further acknowledge that I have received a copy of the Hospital's Notice of Privacy Practices.

____ _____/_____/_____ _____/_____/_____
Printed Name of Patient Patient DOB Date

____ _____/_____/_____
Signature of Patient or Authorized Representative Date

Reason Patient Unable to Sign: ☐ Incapacitated ☐ Restraints ☐ Other

Relationship to patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other ______________

____ _____/_____/_____
JMH Witness Date