JMH Pediatric Specialists

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 as your 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)

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

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

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

Designation:

I, _____ (print name), hereby nominate the following person 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.

Print Name of Personal Representative: _____

Print Name of Personal Representative: _____

Print Name of Personal Representative: _____

Print Name of Personal Representative: _____

The authority of this person when acting as my personal representative is restricted to the following functions:

- ❑ **This person is to be afforded all of the privileges that would be afforded to me with respect to my or my child's health information.**
- ❑ **Other:** _____

Guarantor Signature: _____ Date: _____
(or patient, if 18 or older)

Revocation:

I understand that by signing this Revocation Section of my copy of this form and returning it to Franklin Pediatrics, I revoke this designation. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my or my child's health information have already acted in reliance on this designation.

_____ _____
Guarantor (or patient, if 18) Signature Date