LAMPREY
HEALTH CARE
Where Excellence and Caring go Hand in Hand

Authorization for Designation of Personal Representative

Patient Name: ______________________________ **DOB:** __________

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the Federal Privacy Rule (45 CFR 164.502 (g), as indicated below.

This designation does not expire but may be cancelled by contacting the LHC Medical Record Department.

My designated Personal Representative is:

Name: ____

Address: ____

Phone #: ____________________ Relationship to patient: ____________________

I request that my Personal Representative be allowed to assist me in exercising the following rights related to my protected health information:

Draw a line through those items that do not apply.

My Personal Representative may discuss my care with my provider or other health care staff as applicable
My Personal Representative may schedule appointments
My Personal Representative may discuss and receive billing information

Other ____

In addition, I authorize Lamprey Health Care to release/discuss with my Personal Representative information relating to the following:

Draw a line through those items that do not apply.

- Acquired Immunodeficiency Virus HIV Infection
- Psychiatric Care
- Genetic Testing
- Treatment for alcohol and/or substance abuse

______________________________ ______________
Signature of Patient or Legal Guardian/Parent Date

______________________________ ______________
Print name of Patient or Legal Guardian/Parent Relationship to Patient