



Designation of Personal Representative

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, _____ (print name) SS# _____ - _____ - _____ or
DOB ____/____/____ hereby nominate the following person to act as my personal representative
with respect to decisions involving the use and/or disclosure of health information that pertains to
me and/or for language interpretation:

(Print Name of Personal Representative)

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

_____(initial) **This person is to be afforded all of the privileges that would be afforded to me with
initial respect to my health information.**

OR

_____(initial) **This person is to be afforded all of the privileges that would be afforded to me
with initial respect to my health information except:** (please specify) _____

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 LWHA. I further understand that any such a revocation does not
apply to the extent that persons authorized to use or disclose my health information have already
acted in reliance on this designation.

Patient Signature and Date

REVOCACTION SECTION (To be signed only if revoking the above designation)

I hereby revoke this designation of a personal representative.

Patient Signature and Date