



### DESIGNATION OR REVOCATION PERSONAL REPRESENTATIVE

The Health Insurance and Portability Act of 1996 (HIPAA), gives you the right to have one or more persons act as your personal representative to make decisions to use or disclose your personal health information. By completing this form you are naming an individual as your authorized personal representative. You may limit their access, and the amount of the information that they can have a decision about. *You also have the right to cancel this designation of the personal representative at anytime.*

**DESIGNATION SECTION**

I, \_\_\_\_\_  
(Print your name, address and phone number **for the individual**)

hereby name the following person to act as my personal representative with respect to decisions involving the use and/or sharing of health information that pertains to me.

\_\_\_\_\_  
(Print name, address and phone number **for personal representative**)

**LIMITS TO THE AMOUNT OF INFORMATION DISCLOSED**

- This person is to be provided all of the privileges that are provided to me (individual) with respect to my health information.
- This person is acting as my personal representative only for the following functions:

List details: \_\_\_\_\_ /: \_\_\_\_\_  
\_\_\_\_\_ /: \_\_\_\_\_

I understand that I may cancel the designation at any time by signing the revocation section below. The further understand that any cancellation will only apply to future disclosures of actions regarding my personal health information and cannot cancel actions or disclosures made while the designation was in effect.

*I will retain a copy of the designation and/or revocation form for personal reference, and originals will be kept on file for the period of time designated for such retention.*

Signature of Individual: \_\_\_\_\_ Date: \_\_\_\_\_

**I, hereby revoke the designation of \_\_\_\_\_, as my personal representative.**

Signature of Individual: \_\_\_\_\_ Date: \_\_\_\_\_

Designee/Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_