



Grants Pass Clinic, L.L.P.

495 SW Ramsey Ave, Grants Pass, OR 97527
541-476-6644

**RETURN TO HIPAA
CONTACT PERSON**

DESIGNATION OF PERSONAL REPRESENTATIVE

- Federal law says that Grants Pass Clinic, LLP cannot share your health information without your permission except in certain situations. (See our Notice of Privacy Practices). If you sign this form, you are giving us permission to share your health information with the person(s) you name as your Personal Representative.
- You can name more than one person as your Personal Representative.
- This Personal Representative Designation will last until you tell the Grants Pass Clinic, LLP you do not want it to treat the person(s) you name below as your Personal Representative any longer.
- **Right to Revoke:** If you decide you do not want the person(s) you name below to act as your Personal Representative any longer, you have the right to revoke this designation. Any revocation can only apply on and after the date that we receive your Revocation. We cannot cancel any disclosures made before we received the Revocation.
- Designation of a Personal Representative **does not** take the place of a Power of Attorney. It **does not permit release of my medical records.**

PATIENT NAME _____ DATE OF BIRTH _____

CHART NUMBER _____

I name the following person(s) to act as my Personal Representative:

NAME	PHONE	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have had full opportunity to read and consider the contents of this designation, and I confirm that the contents are consistent with my direction to Grants Pass Clinic, LLP. I understand that by signing this form, I am confirming my designation of a personal representative and that Grants Pass Clinic, LLP may use and/or disclose my protected health information to the person(s) named on this form. This information may include: appointment information, insurance/reimbursement/account billing information and all information pertaining to my treatment. This form shall be in effect until I revoke the Personal Representative Designation by signing the Revocation, below, and give it to Grants Pass Clinic, LLP.

Print Name _____

Signature _____ Date _____

REVOCAATION:

I no longer want the person named above to act as my Personal Representative.

Signature _____ Date _____