Grants Pass Clinic, L.L.P.
495 SW Ramsey Ave
Grants Pass, OR 97527
541-476-6644

MRN_____

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_____

First Designee I name the following person to act as my personal representative:

Designee Name: _____ Relationship to Patient: _____

I authorize the Designee to have the following specific information in order to participate in my care (check each box that applies):

☐Appointment information ☐All healthcare information to coordinate care
☐Billing information ☐Other: _____

Alternate Designee I name the following person to act as my personal representative:

Designee Name: _____ Relationship to Patient: _____

I authorize the Designee to have the following specific information in order to participate in my care (check each box that applies):

☐Appointment information ☐All healthcare information to coordinate care
☐Billing information ☐Other: _____

Alternate Designee I name the following person to act as my personal representative:

Designee Name: _____ Relationship to Patient: _____

I authorize the Designee to have the following specific information in order to participate in my care (check each box that applies):

☐Appointment information ☐All healthcare information to coordinate care
☐Billing information ☐Other: _____

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 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_____

REVOCATION:

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

Signature_____ Date_____