EASTERN CAROLINA WOMEN'S CENTER, P.A.

Personal Representative Designation

Date of Designation: _____, 20__

Patient Name: _____

Date of Birth: _____ Social Security No.: _____

Patient Address: _____

Telephone (H): _____-_____-_____ (W): _____-_____-_____

Pursuant to the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), **Eastern Carolina Women's Center, P.A. (**the "Practice") cannot share your personal health information without your consent except in certain circumstances. By signing this form, you are giving the Practice permission to treat the person you name as your Personal Representative under HIPAA, to share your health information with that person, and to allow that person to exercise certain rights you have under HIPAA with respect to your protected health information. You can name more than one person as your Personal Representative by completing and submitting more than one copy of this form to the Practice. **THIS DOCUMENT DOES NOT AUTHORIZE THE PERSONAL REPRESENTATIVE TO MAKE DECISIONS REGARDING YOUR HEALTHCARE TREATMENT.**

This Personal Representative Designation will continue in effect until you inform the Practice that you do not want the Practice to treat the person you name below as your Personal Representative any longer. If you decide you do not want the Practice to treat the person you name below as your Personal Representative any longer, you will be asked to sign the Revocation on this form and provide it to the Practice. Any revocation can only apply on and after the date the Practice receives the Revocation. The Practice cannot cancel disclosures it made to the Personal Representative before it received the revocation.

Name of Personal Representative: _____

□ This person has all the rights that I have to access, amend, request a disclosure of or otherwise exercise my rights in my protected health information, as described in the Practice's Notice of Privacy Practices.

□ This person is acting as my Personal Representative only for these functions:
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.....

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient's representative Relationship to patient or authority to act for this patient

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

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient's representative Relationship to patient or authority to act for this patient