PENINSULA CARDIOLOGY ASSOCIATES

DESIGNATION OF PERSONAL REPRESENTATIVE

For the Use and Disclosure of Protected Health Information

Date: ____________________

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time. Peninsula Cardiology Associates, P.A., in the exercise of professional judgment, can decide that it is not in the best interest of the individual to treat the person as the individual's personal representative, pursuant to 45 C.F.R. 164.502(g). Peninsula Cardiology Associates, P.A. is expressly authorized to answer questions posed by the Personal Representative listed and to openly discuss with them your condition, treatment, test results, prognosis, billing information, and all other information pertinent to your health care, even if you are fully competent to ask questions and discuss your medical condition.

DESIGNATION OF PERSONAL REPRESENTATIVE

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

____ ____

(Print Name of Personal Representative) *(Relationship to Individual)*

LIMITS TO THE AMOUNT OF INFORMATION PROVIDED (Please check one)

_____ The person named above is to be given all of the privileges that would be given to me with respect to my Protected Health Information.

_____ The person named above is acting as my designated personal representative ONLY for the following function(s):

1. ____
2. ____
3. ____
4. ____

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to the Medical Record Department at Peninsula Cardiology Associates, P.A. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Social Security Number: ____________________ Signature: ____

Date of Birth: Phone:

TO REVOKE THIS DESIGNATION of personal Representative, please place an X in the box below, sign and date.

☐	Effective the date written below the person named above is to no longer act as my personal representative.
Signature: ______________________________________	Date ______________