Designation of Personal Representative

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As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I, _____ (print name) hereby nominate the following person to act as my child's personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to my child.

_____

(Print name of Personal Representative)

This person is to be afforded all of the privileges that would be afforded to me with respect to my child's health information.

I understand I may revoke this designation at any time by signing the revocation section of this form and return it to 10210 Westport Rd, Louisville, KY 40241. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____

Signature Date

REVOCATION SECTION
I HEREBY REVOKE THIS DESIGNATION OF A PERSONAL REPRESENTATIVE

_____ _____

Signature Date