LOUISIANA WOMEN'S
Healthcare

Specialists in Obstetrics and Gynecology
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Designation of Personal Representative

As required by the Health Information 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) SS#_____-_____-_____ or DOB _____/_____/_____hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me and/or for language interpretation:

_____
(Print Name of Personal Representative)

The authority of this person when acting as my personal representative is restricted to the following functions:

_____**(initial) This person is to be afforded all of the privileges that would be afforded to me with initial respect to my health information.**

OR

_____**(initial) This person is to be afforded all of the privileges that would be afforded to me with initial respect to my health information except:** (please specify) _____
_____
_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to LWHA. 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.

_____
Patient Signature and Date

REVOCATION SECTION (To be signed only if revoking the above designation)
I hereby revoke this designation of a personal representative.

_____
Patient Signature and Date