



Designation of Personal Representative

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

I, _____ hereby designate the following individual(s) to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Name	Date of Birth	Driver's License #	Other Identification

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: _____

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 **CVT SURGICAL CENTER, A MEDICAL CORPORATION, 7777 Hennessy Blvd., Suite 1008, Baton Rouge, Louisiana 70808**. I further understand that such revocation does not apply to the extent that persons who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

Signature

Date of Birth

Date

REVOCATION

I hereby revoke this designation of a personal representative.

Signature

Date