



Reid Health Physician Associates

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT AND DESIGNATION OF PERSONAL REPRESENTATIVE

Patient Name: _____ Date of Birth: _____

Acknowledgement:

I hereby acknowledge that I received and / or was offered a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by the patient, please indicate relationship: _____

Designation: Declined Revised

I authorize the practice to disclose or provide my protected health information to the following individual(s) who is (are) authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

(Print Name of Personal Representative) (Phone Number)

(Print Name of Personal Representative) (Phone Number)

(Print Name of Personal Representative) (Phone Number)

Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative(s).

Expirations or termination of authorization: This authorization will remain in effect until terminated by you or your personal representative(s).

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed to your personal representative will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Signature Date