DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to nominate one or more person(s) 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(s) as your "personal representative." You may revoke this designation any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I, _____ Date of Birth: _____
hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/ or disclosure of health information that pertains to me.

PRINT NAME OF PERSONAL REPRESENTATIVE(S)	**RELATIONSHIP TO PATIENT:**

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

☐ This person is to be afforded all the privileges that would be afforded to me with respect to my health information

☐ This person is restricted to the following information about my healthcare:

_____

_____

_____

_____ _____

Signature of Patient or Authorized Representative Date

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: Renaissance Medical Group
2870 S. Maryland Pkwy, #220
Las Vegas, NV 89109

I further understand that any such revocation does not apply to the extent that the person authorized to use or disclose my health information have already acted in reliance on this designation.

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

_____ _____
Signature of Patient Date of Birth

_____ _____
Patient Name Date