Assignment of Personal Representative - ***Please print all information****

As outlined in our Notice of Privacy, Holland Dermatology is required by law to make sure that medical information that identifies you is kept confidential. We understand there are certain circumstances in which you as a patient would like to allow us to discuss information including, but not limited to: appointments, test results, treatment plans, medications, and insurance & billing information with a spouse, friend or other family member. You may assign such a person(s) as your personal representative. By assigning someone as your personal representative you are allowing them the same rights to the information contained in your medical record as you have as our patient.

Patient Name: _____ **Date of Birth:** _____

Patients 18 and older:

The following individuals are authorized to be my personal representative(s):

Name	Relationship to Patient	Phone Number	Today's Date

Minor Patients (under 18 years old only):

Please list *parents* below:

Name	Relationship to Patient	Phone Number	Today's Date

*restrictions to biological/adoptive parent's access may only be made in writing, with an appropriate legal document accompanying it.

You may assign additional personal representative such as step-parents, legal guardian's, grandparents – list them below:

Name	Relationship to Patient	Phone Number	Today's Date

I understand that signing this form grants the above individuals access to ALL medical information contained in my/my child's medical record at Holland Dermatology. I also understand Holland Dermatology has no control over the person(s) I have listed as a personal representative; therefore I understand the actions taken by such personal representatives with the information released, is no longer the responsibility of Holland Dermatology. This form may be terminated at any time by submitting a written request to our Privacy Manager. Termination will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

Signature:_____ **Date:**_____

(This form is valid one year from the date of signature)

DO NOT WRITE BELOW THIS LINE:

Renewal of Personal Representative.

I wish to extend the appointed personal representative(s) listed above for an additional year from the date of my signature. I understand that signing this form grants the above named person(s) access to all medical information contained in my medical record at the office of Holland Dermatology. Renewal good for one year form date of signature.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____