FAMILY PRACTICE ASSOCIATES
509 HAMACHER STREET, SUITE 102
WATERLOO, IL 62298

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act o 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, _____hereby nominate the following person/persons to act as my
(print name)
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) (print name of personal representative)

This person or persons is to be afforded all privileges that would be afforded to me with respect to my health information.

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 Family Practice Associates, address listed above. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this on this designation.

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this designation of a personal representative: _____
(print name of personal representative)

_____
Signature Date