CAREMOUNT MEDICAL

caremountmedical.com

NEXT GEN ID #_____
(For Office Use)

DESIGNATION OF PERSONAL REPRESENTATIVE

Patient Name:_____ Date of Birth:_____

Patient Address:
Street:_____ Apartment #:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____

I designate the following person(s) listed below as my personal representative(s) and understand and acknowledge that this designation gives the Personal Representative(s) the same power over my protected health information as I have, including the right to inspect my records, authorize disclosures and request restrictions and amendments. I hereby waive any restrictions on my personal representative(s)' access to my protected health information. I understand that I am not required to list anyone. I also understand this designation shall remain in place until such time as I revoke it in writing by letter to the Privacy Officer of CareMount Medical.

Print Name:_____ Phone Number: _____

Relationship to Patient:_____

Print Name:_____ Phone Number: _____

Relationship to Patient:_____

Print Name:_____ Phone Number: _____

Relationship to Patient:_____

_____ Please check if this represents a change in a previous designation

_____ _____
Signature of Patient/Parent/Guardian Date

Please return to staff member or mail to:
CareMount Medical
90 South Bedford Road
Mount Kisco, NY 10549-3422
ATTN: HIPAA Privacy Officer