Optum Medical Care, P.C.

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 Medical Records Department of Optum Medical Care, P.C.

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:
Optum Medical Care P.C.
100 South Bedford Road
Mount Kisco, NY 10549
ATTN: Medical Records Department

or via fax:
914-242-1393

or via email:
medrec1@caremount.com