[+ ·sonal Representative Designation

The purpose of this form is to designate a patient's Personal Representative(s) for discussion and disclosure of Personal Health Information. The designation is voluntary and in no way affects benefits, claims processing and payment, or eligibility status.

Patient information

Name: ____________ Date of Birth: mm/dd/yyyy

Type of information

Integrative Family Medicine may discuss or release Personal Health Information to the Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through **Integrative Family Medicine.**

Authorized use and/or disclosure

I authorize **Integrative Family Medicine** to release Personal Health Information to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider or other person subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. **Integrative Family Medicine** is not responsible should my Personal Representative further disclose my protected Personal Health Information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating a "no limitation" on disclosure of Personal Health Information.

Disclosure limitations:

Expiration and revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan Administrator. Revocation will not affect any action that **Integrative Family Medicine** has taken or any information that has already been released based upon prior authorizations.

Designation of personal representatives(s)

Name of authorized person: ____________ Relationship to patient: ____________ Phone Number: ____________

Name of authorized person: ____________ Relationship to patient: ____________ Phone Number: ____________

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Signature and authorization

I, the undersigned, do hereby swear that I am the above-mentioned patient or an authorized legal representative of the above-mentioned patient. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

Name: ____________

Relation to Patient (if signed by legal representative): ____________ Date: MM/DD/Y`

Please sign with mouse or finger:

Clear Signature