



Designation of Personal Representative

Patient's Name:	Patient's Date of Birth:
Patient's Address:	

Under the HIPAA Privacy Rules, Rao Heart & Vascular, LLC may disclose the above-name patient's protected health information to a designated person representative (for example, a family member or friend).

By signing below, I hereby authorize the following individual(s) to serve as the patient's personal representative(s) in order to obtain and access protected health information regarding the patient's treatment at Rao Heart & Vascular.

1. _____ Relationship to Patient: _____ Phone: _____
2. _____ Relationship to Patient: _____ Phone: _____
3. _____ Relationship to Patient: _____ Phone: _____

This designation is voluntary and continuous in nature. The designated person representative(s) will be able to obtain and access the patient's health information until such time as you and/or the patient, whichever is applicable, instructs Rao Heart & Vascular otherwise in writing. Revocations or changes to this designation will not apply to information that has already been released by Rao Heart & Vascular.

A photocopy of facsimile of this form shall be valid and effective, just as the original.

Signature of Patient

Date

Signature of Legal Guardian (*if applicable*)

Date