

Independent Physicians

If you would like to have any family member be able to call the office about your medical condition or to have knowledge of your care at our office, please complete this form. Each person’s name will need to be on this form. Please bring this form with you to your office visit. Thank you!

Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf in discussion and reviewing your health care information. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Note that subject to the disclaimers in the following paragraph, this form may be used to document the following types of personal representative relationships: 1) making appointments for health care services, 2) discussion with health care providers about routine tests and treatments (do not require informed consent) and 3) access to medical records.

Note that this form is not applicable and cannot be used for behavioral health patients or for any patient whose major health care decisions are involved, including but not limited to: 1) procedure/services that require informed consent (and withdrawal of consent if applications), 2) admissions to and discharges from nursing homes or other long term care facilities, 3) donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy, and 4) continuation or withdrawal of life support. For major health care decisions, a formal power of attorney or living will is recommended.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

This personal representative designation only applies to the following (health care provider staff must fill in this blank): Alleghenies Pulmonary Associates.

Patient Name: _____

To Whom May We Give Information About Your Medical Condition:

1. _____ **Relationship to you:** _____

2. _____ **Relationship to you:** _____

3. _____ **Relationship to you:** _____

4. _____ **Relationship to you:** _____

2. Required Signatures

Patient Signature: _____ Date: _____