EYE PARTNERS, P.C. D/B/A EYE CENTER SOUTH

Designation of Personal Representative

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

Under the HIPAA Privacy Rules, Eye Partners, P.C. d/b/a Eye Center South may disclose the above-named patient's protected health information to a designated personal 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 Vision Center South:

1. ____ Relationship to Patient: ____________________

2. ____ Relationship to Patient: ____________________

The following type of health information may not be disclosed to the personal representative(s) pursuant to this designation (if none, include "None"): ____

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This designation is voluntary and continuous in nature. The designated personal 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 Eye Center South otherwise in writing. Revocations or changes to this designation will not apply to information that has already been released by Eye Center South.

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

____ ______________________________
Signature of Patient Date

____
Medical Record Number

____ ______________________________
Signature of Parent or Legal Guardian (*if applicable*) Date