

Personal Representative Designation Form

I want to be very careful about who has access to the personal information in your chart or health record. Please tell me who may receive information about you or your child under ordinary circumstances, and who is available to contact under emergency circumstances. Please also specify any restrictions you want placed on the information given out. You may change the information on this form at any time. If you have any questions, please ask Della Wright or Dr. Joan Moreau.

Please do not include physicians, counselors or other health care providers. We have release of information forms for your health care providers.

REQUIRED INFORMATION:

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

Who may receive information about you/your child under ordinary circumstances?

NAME: _____ PHONE # _____

ADDRESS: _____

RELATIONSHIP TO THE PATIENT: _____

Any limitations? Yes No Anything that will help my treatment Minimal

If yes, please specify: _____

NAME: _____ PHONE# _____

ADDRESS: _____

RELATIONSHIP TO THE PATIENT: _____

Any limitations: Yes No Anything that will help my treatment Minimal

If yes, please specify: _____

Who may receive information about you/your child under emergency circumstances?

NAME: _____ PHONE# _____

ADDRESS: _____

RELATIONSHIP TO YOU: _____

If there are more people that you would like to list, please add them to the reverse side of this form.