

**DESIGNATION OF PERSONAL REPRESENTATIVE**  
**For the Use and Disclosure of Protected Health Information**  
**Not to be Used for EIC - Medicare**

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time. Envision, in the exercise of professional judgment, can decide that it is not in the best interest of the individual to treat the person as the individual's personal representative. See the Envision's Privacy Policy and Procedures on *Personal Representatives*, pursuant to 45 C.F.R. 164.502(g).

Date: \_\_\_\_\_

**DESIGNATION OF PERSONAL REPRESENTATIVE**

I, \_\_\_\_\_ (print your name) hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and / or sharing of protected health information that pertains to me.

\_\_\_\_\_  
(Print Name of Personal Representative)

\_\_\_\_\_  
(Relationship to Individual)

**LIMITS TO THE AMOUNT OF INFORMATION PROVIDED – Please check one**

\_\_\_\_\_ The person named above is to be given all of the privileges that would be given to me with respect to my protected health information.

\_\_\_\_\_ The person named above is acting as my designated personal representative **ONLY** for the following function(s):

\_\_\_\_\_  
\_\_\_\_\_

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to (Medical Records) address listed below. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Member ID number: \_\_\_\_\_ Signature: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**REVOCACTION SECTION**

I no longer want this person to act as my personal representative.

Member ID number: \_\_\_\_\_ Signature: \_\_\_\_\_

**PLEASE MAIL TO: 2181 E. Aurora Rd, Twinsburg, OH 44087 OR FAX TO: 1-866-250-5178**