ATX PRIMARY CARE
KEEPING AUSTIN HEALTHY

Personal Representative Designation

Patient First/Last Name:_____ DOB:_____

The purpose of this form is to designate a patient's Personal Representative(s) for discussion and disclosure of Personal Health Information (PHI.) Although this designation is a voluntary form, ATX Primary Care must have this on file if you would like a relative or another person to be able to communicate with ATX Primary Care on your behalf.

Authorized Use and/or Disclosure

I understand Personal Health Information (PHI), includes, but is not limited to, identification of treating providers of care, diagnoses, procedures, demographic information and medical information used to make payment decisions.

If the designated Personal Representative(s) listed below is not a health care provider or other person subject to federal privacy laws, PHI may no longer be protected by those privacy laws and may by subject to re-disclosure by the Personal Representative(s.) ATX Primary Care is not responsible should my Personal Representative(s) further disclose my protected PHI.

I further understand that I have the right to limit the information that ATX Primary Care can release under this authorization. Limitations for disclosure have been identified below. By leaving this section blank, I am creating a "no limitation" on disclosure of Personal Health Information.

Disclosure limitations: _____

Expiration and Revocation

I may revoke this authorization at any time, providing a written notice to ATX Primary Care. Any Revocation will only apply on and after the date ATX Primary Care receives the Revocation. Revocation will not affect any action ATX Primary Care has taken or any information that has already been released based upon prior authorizations. ATX Primary Care cannot cancel disclosures it made to the Personal Representative(s) before it received the Revocation.

Designation of Personal Representative(s)

Name of Personal Representative	Relationship to Patient	DOB
_____	_____	_____
_____	_____	_____

Signature AND Authorization

I, the undersigned, do hereby swear that I am the above-mentioned patient or an authorized legal representative of the above-mentioned patient. I authorize ATX Primary Care to release Personal Health Information (PHI) to the person(s) named as my Personal Representative(s.) I have read and understand the content of this Personal Representative Designation.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Printed Name of Patient/Legal Representative Legal Representative relationship to patient