SUNSET HEALTH

DESIGNATION OF PERSONAL REPRESENTATIVE

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, states you have the right to have one (1) 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 the authorized personal representative(s) can access, and you can cancel this at any time.

DESIGNATION OF PERSONAL REPRESENTATIVE

I,_____ Date of Birth_____
hereby name the following person(s) to act as my authorized personal representative(s) with respect to decisions involving the use and/or sharing of protected health information that pertains to me. (Representative must be at least 18 years old.)

PRINT Name of Personal Representative(s)	**Relationship**	**Date of Birth**	**Phone**

☐ I do not wish to assign a DPR at this time.

LIMITS TO THE AMOUNT OF INFORMATION PROVIDED – please check one

☐ The person(s) 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(s) named above is acting as my designated personal representative ONLY for the following functions: _____

This authorization will remain in effect for one year, unless effectively revoked in writing by the patient before that date. I understand I may cancel this designation at any time by signing the revocation section below and returning it to Sunset Health. I understand 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.

_____ _____
Patient/Legal Guardian Signature Date

REVOCATION SECTION

I no longer want the person(s) above to act as my personal representative(s).

_____ _____
Patient/Legal Guardian Signature Date