LAKE COUNTRY FAMILY MEDICINE

PERSONAL REPRESENTATIVE

Patient: ____ Date of Birth: _________________

SS#: ____________________________________ Phone: ______________________________

Address/Apt #: ____

City-State-Zip Code: ____

Please recognize ____
(print name/relationship) as my personal representative to receive health information about me.

Please recognize ____
(print name/relationship) as my personal representative to receive health information about me.

Please recognize ____
(print name/relationship) as my personal representative to receive health information about me.

I understand there is a potential for information disclosed to be re-released by me or the recipient of the information. Lake Country Family Medicine may not condition treatment on whether or not you sign this authorization.

I understand that I may revoke this personal representative recognition, in writing, at any time, except to the extent that action has been taken in reliance on it.

Signed: ____________________________________ Date: _________________________

Witness: ___________________________________ Date: _________________________

If not signed by the patient, please indicate relationship to the patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
- other (specify) ______________________________________

Print Name if not signed by the patient: _________________________________

For office use only:

Date received: ___________________/initials: ___________________

Date request rescinded, in writing, by the patient: ___________________/initials: ___________________