

*Lake Podiatry, PA
144 Highland Street
Unit One
Plymouth, NH 03264*

Patient's Assignment of a Personal Representative

Patient Name: _____ Patient ID#: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

I hereby request that Lake Podiatry, PA (the "Practice") disclose my Protected Health Information ("PHI") to the following named person or entity who will be acting as my Personal Representative:

Personal Representative: _____

Relationship to the Patient: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

I understand and acknowledge that:

1. This authorization is voluntary and I may refuse to agree to its terms without affecting any of my rights to receive healthcare at the Practice.
2. This Authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention "Privacy Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid until revoked or changed.

Name of Individual (Printed)

Signature of Individual

Date

Witness: _____