Fountain Point Imaging Center

Chart #: _____

Patient Name: _____

Date of Birth: _____

Questions? 402-379-2349
3901 W. Norfolk Ave. Suite R • Norfolk, NE 68701
www.FountainPointImagingCenter.com

DESIGNATION OF PERSONAL REPRESENTATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation on your copy of this form and returning it to this office.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Fountain Point Imaging Center, LLC I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____ / _____ / _____

SIGNATURE DATE

DESIGNATION SECTION

I, _____ (PRINT YOUR NAME) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

_____

_____

_____

PRINT NAME(S) OF PERSONAL REPRESENTATIVE(S) & PHONE NUMBER

The authority of this person when acting as my personal representative afforded all of the privileges that would be afforded to me with respect to my health information unless I have listed any restrictions below.

_____

_____

REVOCATION SECTION

I hereby revoke this designation of a personal representative.

_____ _____ / _____ / _____

SIGNATURE DATE