# DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to your personal health information ("Protected Health Information"). By completing this form, you are informing us of your wish to designate the named person as your personal representative with respect to uses and disclosures of your Protected Medical Information.

I, ____________________________________________________________

(PLEASE PRINT NAME AND DATE OF BIRTH)

hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my Protected Medical Information.

______________________________________________________________

(PLEASE PRINT NAME OF PERSONAL REPRESENTATIVE)

The authority of this person, when acting as my personal representative, is restricted to the following functions:

Description:

This person is to be afforded all of the privileges that would be afforded to me with respect to my Protected Medical Information.

I acknowledge and 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 Oklahoma Otolaryngology Associates, LLC, P. O. Box 96-0119, Oklahoma City, OK 73196-0119. I further acknowledge and understand that any such revocation does not apply to the extent that persons authorized to use or disclose my Protected Health Information, has already acted in reliance on this designation.

______________________________________________________________

SIGNATURE DATE

**DECLINATION SECTION**

I hereby decline this Designation of Personal Representative.

______________________________________________________________

SIGNATURE DATE