Allergy & Asthma Center
of Southern Oregon, PC
Kevin W. Parks, MD Ryan B. Israelsen, MD Edward M. Kerwin, MD
Tiffany R. Smith, PA-C Joann L. Reed, MSN, NP-C
Phone (541) 858-1003 Fax (541) 857-4499

Personal Representative Designation Form

Dear Patient,

We understand that you wish to appoint a personal representative to act, *in addition to yourself*, on your behalf as described below. In regards to this matter, the privacy of your healthcare information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your healthcare information. Once you return this completed, signed and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient: 1? Making appointments for healthcare services, 2: discussions with healthcare providers about routine tests and treatments (do not require informed consent), and 3) access to medical records.

Patient Name: _____ DOB: _____

Address: _____ Phone: ( ) _____

_____ Cell: ( ) _____

Patient's Personal
Representative: _____ Relationship: _____

Address: _____ Phone: ( ) _____

_____ Cell: ( ) _____

Are there any limitations on issures your personal representative may discuss? Yes _____ No _____

If yes, please specify. _____

Expiration date for this designation *(this form will remain in effect until rescinded by you in writing)*: _____

Required Signatures

Personal Rep. Signature: _____ DOB: _____

Patient Signature: _____ DOB: _____

Please return this completed form to: **Allergy & Asthma Center**
ATTN: Medical Records Dept.
3860 Crater Lake Ave.
Medford, OR 97504

Or Fax to: 541.857.449