

MARSHALL MEDICAL CENTER
DESIGNATION OF PERSONAL REPRESENTATIVE /
DESIGNEE FOR RELEASE OF INFORMATION

DESIGNATION SECTION

ATTN: _____, Marshall Medical Center Representative

I, _____ (print name) hereby designate the following person to receive information on my behalf as my personal representative / designee with respect to my health and financial information.

Print Name of Personal Representative/Designee (Designee can be a relative, spouse, child, parent, friend, etc.)

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

- This person is to be afforded all of the privileges that would be afforded to me with respect to my health and financial information for all dates of service.
- This person is to be afforded all of the privileges that would be afforded to me with respect to my Health information only.
- This person is to be afforded all of the privileges that would be afforded to me with respect to my Financial information only.
- This person is to be afforded all of the privileges that would be afforded to me with respect to my health and financial information for only the following dates of service: _____.

I understand that this designation does not expire until I revoke it in writing. I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Marshall Medical Center. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health and financial information have already acted in reliance on this designation.

Patient's Signature: _____ Date: _____

Last 4 digits of Patient's Social Security Number: _____

REVOCATION SECTION

I hereby revoke this designation of a personal representative/designee.

Patient's Signature: _____ Date: _____

Translation services utilized.

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