

# EC Evansville Multi-Specialty Clinic, PC

812-491-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-491-1972 • [www.evansvilleclinic.com](http://www.evansvilleclinic.com)

## Appointment of Personal Representative to Receive Protected Health Information

You may rely upon your spouse, relatives or friends from time to time to visit your physician, acquire prescriptions, get test results, schedule appointments, or help you understand your treatment options and alternatives. However, the federal Health Insurance Portability and Accountability Act (HIPAA) and Indiana law do not allow us to disclose any of this information to these people unless you appoint them as a personal representative.

**To appoint an individual as your personal representative, complete this form.**

I HEREBY AUTHORIZE EVANSVILLE MULTI-SPECIALTY CLINIC, PC TO RELEASE THE FOLLOWING PROTECTED HEALTH INFORMATION TO THE INDIVIDUAL(S) I HAVE DESIGNATED:

Print name of Person	Relationship to Patient	Information to be released, such as, appointment times, all Personal health information.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_ I authorize Evansville Multi-Specialty Clinic, PC to leave messages on my voice mail, answering machine or with individuals who may answer the phone.

This authorization will not terminate until a written termination or revocation to this form has been made. As stated in the privacy practices, you have the right to revoke or terminate this authorization by submitting a written request to privacy manager at any time. We have no control over the person (s) you have enlisted as your personal representative. Therefore, your PHI disclosed under this authorization no longer remains protected by the requirements of the privacy rule and will no longer be the responsibility of Evansville Multi-Specialty Clinic, P.C.  
**I MAY REVOKE THIS APPOINTMENT AT ANY TIME. MY REVOCATION WILL NOT AFFECT ANY ACTIONS THAT HAVE BEEN ALREADY TAKEN IN RELIANCE ON MY ORIGINAL APPOINTMENT.**

Print Patient's Name	Patient's Signature	Date
Patient's Street Address	City	State
		Zip Code
Patient's birth date	SS#	