Scripps

DESIGNATION OF PERSONAL REPRESENTATIVE

PATIENT NAME _____

DATE OF BIRTH (DOB) _____

MEDICAL RECORD NUMBER(MRN) _____

CSN _____

WHY THIS FORM?

As required by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, you have a right to designate a person to act on your behalf with respect to your protected health information (PHI). By completing this form you are informing us of your wish to designate the named person as your personal representative. **See page 2 for return instructions.**

Patient Name: _____	**Date of Birth:** _____
Address: _____	**Telephone Number:** _____
_____	

1. Designation of Personal Representative.
At my request, I hereby name the following individual as my personal representative:

Designee Phone Number:_____

Designee Name: _____**Relationship to Patient/Member:**_____

2. I authorize the named Designee to have access to my Protected Health Information in order to do the following related to my healthcare (check each box that applies):

- ☐ Make, change, or confirm appointments.
- ☐ Sign the Request to Obtain a Copy or Authorization for the Use or Disclosure of Health Information form to request a release of my records and/or copies.
- ☐ Speak with a physician regarding the coordination of my care.
- ☐ Speak with the Business Office regarding billing.
- ☐ Grant proxy access to my patient portal.
- ☐ Other: _____

Note: *This form does not take the place of an Authorization for Use and Disclosure of PHI, when requesting copies of records.*

3. Expiration of Designation. This designation will expire as I have noted.

☐ Date: _____

4. Denial of Access to PHI. I understand and acknowledge **MY DESIGNATION OF PERSONAL REPRESENTATIVE MAY BE DECLINED IF:** (1) the information provided is not accurate; (2) this form is not completed in its entirety; (3) I failed to sign below; and/or (4) as prohibited by law.

5. DESIGNATION SIGNATURES

Patient Signature	**Printed Name**	**Date**	**Time**
Witness Signature (Optional)	**Printed Name**	**Date**	**Time**

DPR 100-8720-066SW

100-8720-066SW (4/4/22)

Scripps

REVOCATION OF DESIGNATION OF PERSONAL REPRESENTATIVE

PATIENT NAME _____

DATE OF BIRTH (DOB) _____

MEDICAL RECORD NUMBER(MRN) _____

CSN _____

As required by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, you have a right to REVOKE a designated person from acting on your behalf with respect to your protected health information (PHI). By completing this section of the form you are informing us of your wish to REVOKE the assigned designee as your personal representative.

Patient Name: _____	**Date of Birth:** _____
Address: _____	**Telephone Number:** _____
_____	

1. Name of Designated Personal Representative.
At my request, I hereby REVOKE designation of the following individual as my personal representative:

Designee Phone Number:_____

Designee Name: _____**Relationship to Patient/Member:**_____

Patient Signature	**Printed Name**	**Date**	**Time**
Witness Signature (Optional)	**Printed Name**	**Date**	**Time**

Return Instructions:

USPS: Scripps Health Information
10790 Rancho Bernardo Rd
Mail Drop 4S-220
Rancho Bernardo, CA 92127

E-mail: SMFEmailMR@scrippshealth.org
Submit PDF file format of document

Fax: 858-927-5081

100-8720-066SW (4/4/22)