سدرة للطب
Sidra Medicine

SIDRA MEDICINE
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Designation of Personal Representative

You have a right to designate a person to act on your behalf with respect to your protected health information.

By completing this form you are informing us of your wish to designate the named person as your personal representative.

I hereby authorize the Designee to collect medical records on my/my child's behalf .

At my request, I hereby name the following individual as my / my child's personal representative:

Designee Name : _____ **QID:** _____

Relationship to Patient : _____

Patient Name: _____	**MRN:** _____
_____	**Date of Birth:** _____
QID: _____	**Telephone Number:** _____

Note: *This form does not take the place of an Authorization for Release of Medical Information.*

Expiration of Designation. This designation will expire on Date: _____

Denial of Access .

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.

DESIGNATION SIGNATURES

_____	_____	_____	_____	
Patient/ Parent/Guardian Signature	**Printed Name**	**QID**	**Date**	**Time**