

CHAND ROHATGI, M.D., F.A.C.S.

A PROFESSIONAL CORPORATION

THE BREAST CARE CENTER & GENERAL SURGERY PRACTICE

3735 NAZARETH ROAD, EASTON, PENNSYLVANIA 18045-1963

PHONE 610-252-1999 FAX 610-252-0573

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing Dr. Chand Rohatgi and staff of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Designation Section

I, _____ (print name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

This Person(s) is to be afforded all the privileges that would be afforded to me with respect to my health information.

- | | | |
|---|--------------------|---|
| 1.) _____
Print Name of representative | _____ Relationship | H: (____) _____ - _____
C: (____) _____ - _____
W: (____) _____ - _____ |
| 2.) _____
Print Name of representative | _____ Relationship | H: (____) _____ - _____
C: (____) _____ - _____
W: (____) _____ - _____ |

Signature Date

Revocation Section

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Dr. Chand Rohatgi's office. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Signature Date