UCERA - *University Clinical, Education and Research Associates*

REQUEST FOR PERSONAL REPRESENTATIVE

This form cannot be processed unless filled out completely and signed.

PATIENT NAME: _____ BIRTHDATE _____

PATIENT ADDRESS: _____

_____

Under federal law, you have a right to nominate one or more persons to act on your behalf with respect to your health information. By completing this form, you are informing UCERA of your wish to designate the named person(s) as your personal representative(s).

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 my health information. I understand that my treatment will not be conditioned on whether I sign this designation.

PERSONAL REPRESENTATIVE'S NAME: _____

PERSONAL REPRESENTATIVE'S ADDRESS: _____

_____

PERSONAL REPRESENTATIVE'S RELATIONSHIP TO YOU: _____

CHOOSE ONE OF THE TWO OPTIONS BELOW

☐ My designated personal representative is afforded all the privileges that would be afforded me with respect to my health information

☐ My designated personal representative's authority is restricted to the following: (describe) _____

_____

_____

NOTE: If PHI is disclosed under your authorization to persons or organizations not subject to federal privacy laws, it may be re-disclosed and no longer protected.

This authorization will expire on: (enter date) ___/___/___ ; OR when the following occurs: _____

_____

I understand that I may revoke this designation at any time by sending a written notification to UCERA at the address below. I further understand that any such revocation does not apply to the extent that UCERA has already acted in reliance on this designation.

Signature: _____ Date: _____

Mailing Instructions:
Please mail completed form to

UCERA Privacy Officer
677 Ala Moana Blvd., Suite 1003
Honolulu, HI 96813

Rev. 2/27/09