PATIENT APPOINTMENT OF REPRESENTATIVE

I hereby appoint the person listed below to be my representative. I authorize you to use and disclose my private healthcare information (PHI) to this representative. I have the right to rescind this appointment at anytime with written notice to GHS.

This person may receive my PHI and discuss this information in my treatment and/or payment.

Name of Representative: _____

Birth Date of Representative: Month _____ Day _____

Relationship to Patient: _____

Does this person have Medical Power of Attorney? _____

Timeframe of Appointment: From this day forward with no restrictions: _____

Date to/from: _____

Name of Patient: _____

Signature of Patient: _____

Date: _____