



YANKTON MEDICAL CLINIC®, P.C.

An Avera Partner

Chart #: _____

Date of Birth: _____

Questions? 605-665-7841

1104 West 8th Street • Yankton, SD 57078

www.YanktonMedicalClinic.com

DESIGNATION OF PERSONAL REPRESENTATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 us 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 on your copy of this form and returning it to this office.

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 Yankton Medical Clinic, P.C. 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

DESIGNATION SECTION

I, _____ (PRINT YOUR 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.

PRINT NAME AND PHONE NUMBER OF PERSONAL REPRESENTATIVE

The authority of this person when acting as my personal representative afforded all of the privileges that would be afforded to me with respect to my health information unless I have listed any restrictions below.

Enter the phone number of the individual to whom the doctor and staff have permission to release information. _____

REVOCACTION SECTION

I hereby revoke this designation of a personal representative.

SIGNATURE

____ / ____ / ____
DATE

WITNESS

SIGNATURE

DATE: ____ / ____ / ____