OTMDC | Olde Towne Medical & Dental Center

Designation of Personal Representative

You may designate a personal representative who will act on your behalf in making decisions related to health care, which includes treatment and payment issues. This individual can be a family member, friend, lawyer, or unrelated party.

Please print neatly to ensure correct and prompt processing.
We reserve the right to return any illegible or incomplete form.

I hereby designate the following individual as my personal representative:

Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Please read each of the following statements carefully before signing this document.

1. I understand that this designation will NOT expire while you are under the care of Olde Towne Medical and Dental Center unless I indicate an expiration or I revoke it. *Date to expire*: _____
2. I understand that this designation is voluntary and being made at my request.
3. I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives the information.
4. I understand that I may refuse to sign this designation form. OTMDC will not condition treatment and will not condition payment or eligibility on my signing this designation.
5. I understand that I may revoke this designation of personal representative at any time by sending a written notification to the Privacy/Security Officer at the address listed below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that OTMDC has already used or disclosed, relying on this designation.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

If the person signing this form is not the member, or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.)

Please bring with you to your appointment or fax to OTMDC, Attn: Privacy Dept., Fax: 757-220-1953.
Please keep a copy of this designation for your records.

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by written consent of the person to who it pertains, or as otherwise permitted by (42 CFR Part 2). A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.