STAT WELLNESS
PRIMARY HEALTHCARE

PERSONAL REPRESENTATIVE DESIGNATION

I, _____, authorize STAT Wellness Center to release protected health information to the person(s) named as my Personal Representative for assisting with my healthcare, or facilitating the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my protected health information may no longer be protected by privacy laws and may be subject to further disclosure by my Personal Representative. STAT Wellness Center is not responsible if my Personal Representative further discloses my protected health information. I further understand that I have the right to limit the information that is released under this authorization.

Designation of Personal Representative(s)

Name of Authorized Person	Relationship to Patient	Authorized Persons DOB

_____

Signature of Patient Date

_____

Print Name of Patient Date