THE SPINE CENTER OF LOUISIANA

Designation of Personal Representative

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization you are informing us of your designation of the named person as your personal representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

I, _____hereby designate _____, to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: _____
Representative's Date of Birth _____
Representative's Driver's License No. or other
Picture ID No. _____

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: _____

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 **THE SPINE CENTER OF LOUISIANA, INC.**, 9001 Summa Ave, Suite 346, Baton Rouge, Louisiana 70809. I further understand that such revocation does not apply to the extent that persons who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

_____ _____
Signature Date

Last Four Digits of SS #_____

Date of Birth_____

REVOCATION

I hereby revoke this designation of a personal representative.

_____ _____

Signature Date