DESIGNATION OF PERSONAL REPRESENTATIVE
(For Use and Disclosure of Health Information Only)

The physicians and staff at Shreveport Internal Medicine take your medical confidentiality very seriously. We will not and cannot release information without you5r written consent.

This authorization form, when completed and signed by you, allows our staff members to speak only with an individual or individuals you designate in the event that you are not available to receive our phone calls or you have an adult family member that helps coordinate your care.

Please check all areas that you are comfortable allowing us to talk to another person regarding you and your medical care. If you wish to authorize more than one person, please complete the next section as you did the first.

I hereby authorize employees of Shreveport Internal Medicine to speak with the following individual or individuals on my behalf:

Representative Name & Relation:	**Representative Name & Relation:**
Phone Number/s:	**Phone Number/s:**
Regarding: ☐ **Appointments** ☐ **Account Balance/ Bill** ☐ **Medical Care**	**Regarding:** ☐ **Appointments** ☐ **Account Balance/ Bill** ☐ **Medical Care**

☐ **I do <u>NOT</u> authorize anyone to receive information regarding my medical care.**

_____ _____

Patient's Printed Name Date

_____

Patient's Signature

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REVOCATION SECTION

I hereby revoke the above authorized representative:

_____ _____

Representative's Name Date

_____

Patient's Signature

☐ **I HEREBY REVOKE THE ABOVE AUTHORIZATION IN FULL**