Lakeshore Internal Medicine and Pediatric Associates

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Assignment of Personal Representatives (patient must be 18 years and older)

As outlined in our Notice of Privacy Practices our office is required by law to make sure that medical information that identifies you is kept private and confidential. However, we understand that there are certain circumstances in which you as a patient may wish to allow us to discuss information including but not limited to: appointments, test results, treatment plans, medications and insurance and billing formation with a spouse, friend or other family member. You may assign such a person(s) as your personal representative. By assigning a person as your personal representative you are allowing them the same rights to the information contained in our medical record as you, your have as our patient. We may collaborate with other physicians/facilities to keep you healthy.

Patient Name:________________________________ **Date of Birth:**_________________
(Print Name)

Personal Representative Name	Relationship to patient	Phone Number	May we use as Emergency Contact	Today's Date
			Yes No	
			Yes No	
			Yes No	

I understand that signing this form grants the above named person(s) access to ALL medical information contained in my medical record at the office of Lakeshore Internal Medicine and Pediatric Assoc. I also understand that actions taken by such personal representatives with the information that has been released to them is no longer the responsibility of the office

Signature:____ Date:_______/________/________
(VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE)

DO NOT WRITE BELOW THIS LINE

This portion of form to be completed one year after original signature

Renewal of Assignment of Personal Representatives (patient must be 18 years or older)

I wish to extend the appointed personal representatives listed above for an additional year from the date of my signature. I understand that signing this form grants the above named person(s) access to all medical information contained in my medical at the office of Lakeshore Internal Medicine and Pediatric Assoc. Renewal good for one year from date of signature

Signature:____ Date:_______/_______/________

Signature:____ Date:_______/_______/________

Signature:____ Date:_______/_______/________

Signature:____ Date:_______/_______/________

Signature:____ Date:_______/_______/________