University Health Services

1202 W. Farm Rd.
Stillwater, OK 74078
O | 405-744-7665
F | 405-744-6556
uhs.okstate.edu

DESIGNATION OF PERSONAL REPRESENTATIVE

TO ALLOW ANOTHER PERSON TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

*Please include a copy of the OSU ID, Driver's License, State ID card, or equivalents for **both** the Patient and Designated Personal Representative, and any available documentation providing legal authority.*

The patient listed below must present their identification and this designation in person at University Health Services.

I, (PRINT name of patient) ____,

name and appoint (PRINT name of representative), ____

to serve as my Designated Personal Representative.

I understand that my Designated Personal Representative will have access to information about me that is created by or on behalf of Oklahoma State University Health Services, and that this information can include Protected Health Information. My Designated Personal Representative is to be provided with information about me, on my behalf, in order to assist me as I request of them. I understand that my Designated Personal Representative may disclose my information to a third party, and that Oklahoma State University Health Services has no control over that additional disclosure and cannot protect the information after it is provided to my Designated Personal Representative.

I understand I may revoke this designation at any time, either by mail or in person at the address above. I understand this designation will not expire unless and until I actively revoke it.

I understand that my choice to designate or not designate a Designated Personal Representative will not affect my health care treatment, payment, enrollment, or eligibility for benefits.

I understand this completed form does **NOT** allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions, treatment or psychotherapy notes, HIV/AIDS testing or status, or sexually transmitted infection, if any.

I understand I may limit the amount of information my Designated Personal Representative is given access to.

I choose to limit the access of my Designated Personal Representative to only the following information:

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Patient Signature ____ Date ____________________

Parent or Legal Guardian may sign on behalf of minor child. A Legal Guardian, Power of Attorney, or equivalent may sign on behalf of an adult – documentation is required.

Patient Date of Birth ____________________________________ Patient Banner ID_________________________________

Designated Personal Representative Name ____

Designated Personal Representative Relationship to Patient ____

Designated Personal Representative Phone Number ____