HIPAA PRIVACY RULES
DESIGNATION OF PERSONAL REPRESENTATIVE

I, _____, DOB _____
hereby designate _____, DOB_____
as my personal representative for purposes of all rights, obligations and responsibilities created under the HIPAA Privacy Rules.

I acknowledge and agree that Wayne Regional Eye Center (the "Practice") may disclose my protected health information to my personal representative and that my personal representative has the authority to authorize the Practice to use and disclose my protected health information.

_____ _____

Dated Signature of Patient