Grassi Retina
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Notice of Personal Healthcare Representative Designation Form

Federal law says that Grassi Retina MD SC cannot share your Protected Health Information without your permission. If you sign this form, you are giving Grassi Retina MD SC permission to share your Protected Health Information with those person(s) you name as your Personal Healthcare Representative.

- You can name more than one person as your Personal Healthcare Representative.
- The Personal Healthcare Representative designation will last until you tell Grassi Retina MD SC that you do not want the person(s) named below as your Personal Healthcare Representative any longer.
- Right to Revoke: If you decide you do not want us to treat any of the person(s) below as your Personal Healthcare Representative, please inform us and we will give you a new form. The Practice cannot cancel disclosures that were already made to a Personal Healthcare Representative.
- You can keep a copy of this Personal Healthcare Representative form and can contact Grassi Retina MD SC to get an additional copy.
- This form allows Grassi Retina MD SC staff to **speak verbally** to the following individuals about my medical care, without informing me, including clinical information, billing information, insurance information, appointment dates and times, and any other information they seek.
- This form allows Grassi Retina MD SC staff to **share written/printed medical records and/or give access to the patient portal** to the following individuals about my medical care, including clinical information, billing information, insurance information, appointment dates and times, and any other information they seek.

I _____ hereby give my consent to Grassi Retina MD SC to treat the following person(s) as my Personal Healthcare Representative(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to Grassi Retina MD SC. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my Protected Health Information. Written revocation of consent must be sent to Grassi Retina MD SC 1012 95th street Naperville, IL 60564.

Patient Signature: _____ Date: _____

NOTE: If patient is not able to sign, please provide name and relationship of anyone to helping to fill out this form

Name: _____ Relationship: _____