DESIGNATION OF PERSONAL REPRESENTATIVE

In addition to myself, I designate to the following individual(s) as my personal representative and grant RedCedar Family Practice permission to disclose (written and/or verbal) my Protected Health information with the individual(s) named below.

Name of representative	**Relationship to patient**
Name of representative	**Relationship to patient**
Name of representative	**Relationship to patient**

I understand that I may revoke this authorization at any time.

( ) I chose not to designate any other person as my personal representative.

Signature of patient	**Date of receipt**

Date of Birth