DERMATOLOGY, P.C.
6000 University Ave, Suite 450
West Des Moines, IA 50266
(515) 241-2000

PATIENT AUTHORIZATION FOR A PERSONAL REPRESENTATIVE

Patient Name:____

Social Security Number (last 4 digits):____________________ **Date of Birth**:_____________________________

Purpose of request: I authorize Dermatology, P.C. to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information.

____(______)__________________
Name of Personal Representative Telephone

____
Representative Address:

____
City, State, Zip Code

- **Description of information to be disclosed:** I authorize Dermatology, P.C. to disclose all of my protected health information to my designated Personal Representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you (the patient), your personal representative, or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or in writing by mailing your request to:

DERMATOLOGY, P.C.
ATTN: HIPAA PRIVACY MANAGER
6000 UNIVERSITY AVE, SUITE 450
WEST DES MOINES, IA 50266

Re-disclosure: We have no control over the person(s) that you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Dermatology, P.C.

____ ______________________
Patient Signature **Date**

Copies of signed authorizations are available upon request.