Mid-Ohio Pediatrics and Adolescents
595 Copeland Mill Rd
Westerville OH 43081
(614)899-0000 (614)899-0524 fax

APPOINTMENT OF PERSONAL REPRESENTATIVE TO RECEIVE PROTECTED HEALTH INFORMATION

_____ _____ ___/___/_____
Child's First Name Last Name Date of Birth

I, (parent/legal guardian) _____ give permission to _____

relationship to child _____ as follows (check one):

___ I give permission for my Personal Representative to seek treatment at Mid-Ohio Pediatrics and Adolescents, Inc. until I revoke this appointment in writing.

___ I give permission for my Personal Representative to seek treatment at Mid-Ohio Pediatrics and Adolescents, Inc. from ____/____/_____ to ____/____/_____

____ I give permission for this person to seek treatment (including any type of minor procedure or diagnostic test, etc.) and provide consent for such treatment if attempts to contact me are unsuccessful.

____ I give permission for this person to seek treatment (including any type of minor procedure or diagnostic test, etc.) and provide consent for such treatment **without** having to contact me.

Please contact my representative at (_____)_____ during my absence.

_____ ____/____/_____
Parent/Legal Guardian's Signature Date

Received by MOP _____ Date ____/____/_____ Patient Acct # _____

I may revoke this appointment at any time by signing below. **Please note revocations do not apply to information that has already been disclosed or used before revocation date.**

I _____ wish to revoke the above named representative.

_____ ____/____/_____
Parent/Legal Guardian's Signature Effective Date