MID-OHIO PEDIATRICS & ADOLESCENTS, INC.
465 N. CLEVELAND AVE. SUITE 200
Westerville OH 43082
(614)899-0000 (614)899-0524 fax

APPOINTMENT OF PERSONAL REPRESENTATIVE TO RECEIVE PROTECTED HEALTH INFORMATION

_____ _____ ___/___/_____
Patient First Name Last Name Date of Birth

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

relationship to patient _____ 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 ____/____/_____ while I am on vacation, military service, business or out of the country.

I hereby authorize Mid-Ohio Pediatrics and Adolescents, Inc. to release the following protected health information to my Personal Representative:

___ All personal health information

OR one or more of the following choices:

___ Pertinent information needed for treatment during my absence.

___ Times of appointments

___ Prescriptions

___ Test results

___ Copies of medical records

___ Other specified instructions: _____

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

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

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