NONA MEDICAL ARTS

Multidisciplinary Pain Management & Regenerative Medicine

PATIENT DESIGNATION DISCLOSURE FORM

I. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ **Password will be patient's date of birth:** _____
Print Name: _____ **Password will be patient's date of birth:** _____
Print Name: _____ **Password will be patient's date of birth:** _____

I, _____, am acting on behalf of my minor son/daughter _____
Parent/Guardian (print) **Name of Patient**
as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

II. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:
_____
_____ OK to leave message with detailed information
_____ Leave message with call back numbers only

Written Communication Address:
_____
_____ OK to mail to address listed above
_____ E-mail me at: _____

Work Telephone Number:
_____
_____ OK to leave message with detailed information
_____ Leave message with call back numbers only

Fax Communication:
_____
_____ OK to Fax to the number listed above

Other: _____

_____ _____
Name of Patient (Print) Signature Date

_____ _____
Witness: Date:

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