

**University of Pittsburgh Medical Center (UPMC)  
Personal Representative Designation Form**

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient: 1) making appointments for health care services; 2) discussions with health care providers about routine tests and treatments (do not require informed consent); and 3) access to medical records as necessary to have discussions with health care providers about routine tests and treatments.

Note that this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to: 1) procedures/services that require informed consent (and withdrawal of consent if applicable); 2) admissions to and discharges from nursing homes or other long-term care facilities; 3) donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy; and, 4) continuation or withdrawal of life support. For major health care decisions, a formal power of attorney or living will is recommended.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

*This personal representative designation only applies to the following UPMC entity/office/clinic (UPMC health care provider staff must fill-in this blank):* \_\_\_\_\_

**1. Required Information**

|   |                          |                                |
|---|--------------------------|--------------------------------|
| Patient's Name:   | Patient's Date of Birth: | Patient's Phone:               |
| Patient's Address:  |                          |                                |
|   |                          |                                |
| Name of Patient's Personal Representative:  |                          | Personal Representative Phone: |
| Personal Representative Address:  |                          | Personal Representative Fax:   |
| Any limitations on issues your personal representative may discuss? Yes _____ No _____<br>If yes, please specify:   |                          |                                |
| Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect indefinitely or until patient expires): |                          |                                |

**2. Required Signatures**

Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this completed form by mail to:

or by fax to:

- 2003(created)
- 11/2005 (rev1)
- 1/2006 (rev2)
- 11/2008 (rev 3)
- 10/2009 (rev4)
- 1/2010 (rev5)