Pezzone Gastroenterology Associates

Manifold Professional Building #3
86 Wellness Way
Washington, PA 15301
724-503-4637

Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf in discussing and reviewing your health care information. In regard to this matter, 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 may be used to document the following types of personal representative relationships: 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.

Note that this form is not applicable and cannot be used for behavioral health patients or any patient when major health decisions are involved, including but not 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, please use pen.

This personal representative designation applies only to Pezzone Gastroenterology Associates.

1. Required Information

Patient's Name:	Patient's Date of Birth:	Patient's SSN:
Patient's Address:		Patient's Phone:
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues you personal representative may discuss? YES ☐ NO ☐ If yes, please specify:		
Expiration date for this designation (unless/until you specify in writing the expiration, this personal representative designation will remain in effect indefinitely:		

2. Required Signatures

Personal Representative Signature:____ Date:____________

Patient Signature:____ Date:____________

Please return this completed form by mail to: Pezzone Gastroenterology Associates
Manifold Professional Building #3
86 Wellness Way
Washington, PA 15301

or by fax to: 724-503-4429