Drs. James & Enyart Optometrists, S.C.

Your Vision Source Headquarters

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Personal Representative Designation Form

You have the right to authorize one or more persons to access and acquire medical information with respect to the **HIPAA** (Health Information Portability and Accountability Act). By signing, you are giving us permission to share authorized medical information to the individual(s) listed below. This form **does not** authorize your personal representative(s) to make medical decisions on your behalf, it only gives your personal representative(s) permission to access and inquire about your protected health information.

Note: You may revoke this designation at any time by written/verbal request.

Please print in ink and fill out completely.

1. Name of Designee _____ Relationship _____

Address _____ Phone_____

2. Name of Designee _____ Relationship _____

Address _____ Phone_____

3. Name of Designee _____ Relationship _____

Address _____ Phone_____

Items to be Discussed with Personal Representatives(s):

_____ Eyeglass/Contact Prescription

_____ Scheduling

_____ Billing and Payment

_____ Diagnosis and Treatment

Patient Signature _____ **Date** _____