Designation Form

JIB Services, LLC / JIB Medical, PC

Patient's Name: _______________________________ Date of Birth: ____________________

I, _____________________________, hereby designate the following individual (the "Designated Person") as a person involved in my health care or payment:

Designated Person's Name: __________________________ Address: _______________________________
____

Relationship to Patient: _____________________________ Telephone Number: _____________________

Patient Statement of Understanding

I understand that by signing this form, I am allowing JIB Medical, PC to disclose to this designated person protected health information about me that directly relates to the designated person's involvement in my healthcare or payment for my healthcare. I understand that in order for JIB Medical, PC to disclose all other information about me to the Designated Person, I must submit a completed Request for Access to Health Information Form to the JIB Medical Privacy Officer.

I have the right to revoke this designation at any time by sending a written request to the JIB Medical Privacy Officer.

____ _______________________
Patient Signature Date

This document must be notarized if submitted to JIB Medical by anyone other than the patient. (Most banks will notarize a document for its customers free of charge.)

NOTARY SECTION – REQUIRED
On this ____________ day of _____________________ 20______, before me personally came _____________________________ who is known to me to be the patient who signed the above request.
____ ________________________ *Notary Public Signature* *Date Signed*