Patient Printed Name:_____

Date of Birth:_____

Medical Record Number:_____

REQUEST FOR DESIGNATION OF THOSE INVOLVED IN MY CARE

Are there people you want to be able to:

- Make/Cancel appointments on your behalf?
- Call in a prescription refill?
- Discuss your medical condition with your physician?
- Discuss your financial statement or insurance concerns?

I request that the South Bend Clinic, LLP and Surgery Center allow communication concerning the above patient's care to those individuals I have listed below. I realize that if agreed to, this designation will stay in effect until I complete a new HIPAA 4000 form.

Printed Name: _____ Relationship/Phone _____

Printed Name: _____ Relationship/Phone _____

Printed Name: _____ Relationship/Phone _____

Emergency Contact

An emergency contact should be someone who has an alternate telephone number than the one listed for you, as our patient, that we may call should we have an emergent health related issue involving your care.

Printed Name: _____ Relationship/Phone _____

*Signature*_____ *Date* _____

Must be signed by the patient or legal guardian. If you have legal paperwork that designates you as the caretaker, please provide copies of that paperwork to the address listed below.

Instructions for processing: Forward completed form to the Privacy Officer, Health Information Management (HIM) Department, South Bend Clinic, 211 N. Eddy Street, South Bend, IN 46617, or bring it to your appointment. The South Bend Clinic is not required to agree to all your requests, however, if reasonable and administratively feasible, we will make every effort to comply**.** ***NOTE: As a designated advocate for the patient, this does not allow any designee to request records on the patient. Such action will require a signed authorization from the patient. Thank you.***

The South Bend Clinic, LLP and SurgiCenter complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.