DESIGNATION OF PERSONAL REPRESENTATIVE

You may designate a personal representative who will act on your behalf in making decisions related to health care, which includes treatment and payment issues. This individual may be a family member, friend, lawyer, or an unrelated party.

1) I authorize: _____

2) To release the records of:

Name: _____

Date of Birth: _____

Identification Number: _____

Address: _____

Home Phone: _____ Work Phone: _____

3) I hereby designate the following individual(s) as my Personal Representative:

A. Name of Individual: _____

Address: _____

City, State, Zip: _____

Telephone: _____

B. Name of Individual: _____

Address: _____

City, State, Zip: _____

Telephone: _____

C. Name of Individual: _____

Address: _____

City, State, Zip: _____

Telephone: _____

D. Name of Individual: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Please read each of the following statements carefully before signing this document.

1. I understand that this Designation will expire *when my employment (or the employment of my spouse or parent) ends* unless I indicate an expiration date or I revoke it.

Date to expire (if chosen): _____

2. I understand that this Designation is voluntary and being made at my request.

3. I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization receiving the information.

4. I understand that I may refuse to sign this designation form and that my healthcare provider will not condition treatment and Loyola University New Orleans Employee Benefit Plan will not condition payment, enrollment, or eligibility on my signing this Designation.

5. I understand that I may revoke this Designation of Personal Representative at any time by sending a written notification to the Privacy Office at the address listed below, and that revocation will be effective for future uses and disclosures of protected health information. However, I further understand that such revocation will not be effective for information that the Loyola University New Orleans Employee Benefit Plan has already used or disclosed, relying on this Designation.

Signature: _____*****

Date: _____

* If the person signing this form is not the member, or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.). . If you are a minor or if this form is being signed on behalf of a minor, the form will expire the day before the minor's 18th birthday if it has not previously been revoked in writing.

Please mail or fax this Designation to: Donna Rochon, the Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax).

Please keep a copy of this Designation for your records.