VMP, llc
Expanding Genetic Horizons

Voice: 404.793.7800
Fax: 866-744-5665
www.vmpgenetics.com

# PERSONAL REPRESENTATIVES

**Dear Patient:**

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the 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 can be used to document the following types of personal representative activities on behalf of the patient: 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 any patient when major health care decisions are involved**, including, but not limited to: 1) procedures/services that require informed consent (and withdrawal of consent if applicable); 2) admission 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, Advanced Directive of Healthcare or living will is recommended.

Read this form carefully and then fill it out completely**.**

## 1. Patient

| | | | | |
|---|---|---|---|---|
| PATIENT NAME | Last | First | Middle Initial | Date of Birth |
| STREET | | | APT | EMAIL ADDRESS |
| CITY | STATE | | ZIP | PHONE NUMBER |

## 2. Patient's Designated Personal Representative:

| | | | | |
|---|---|---|---|---|
| PERSONAL REPRESENTATIVE | Last | First | Middle Initial | PHONE NUMBER |
| STREET | | | APT | EMAIL ADDRESS |
| CITY | STATE | | ZIP | FAX NUMBER |

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Any limitations on issues your personal representative may discuss? Yes ___ No ___

If yes, please specify:

_____

_____

_____

_____

Expiration date for this designation will remain in effect indefinitely,
unless you specify the expiration: _____

**3. Required Signatures**

_____ _____

Patient Signature Date

*This form does not need to be notarized.*

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