CAREMOUNT MEDICAL

caremountmedical.com

NEXTGEN ID# _____
(For Office Use)

REMOVAL OF DESIGNATION OF PERSONAL REPRESENTATIVE

Patient Name:_____Date of Birth:_____

Patient Address:
Street:_____ Apartment #_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____

I hereby request that my prior designation of the following person(s) listed below as my personal representative(s) be removed and understand and acknowledge that this designation revokes the Personal Representative(s) from having any power over my protected health information.

Print Name:_____

Print Name:_____

Print Name:_____

_____ _____
Signature of Patient/Parent/Guardian Date

Please return to staff member or mail to: CareMount Medical, PC, 90 South Bedford Road, Mount Kisco, NY 10549-3422, ATTN: HIPAA Privacy Officer