| NCI Medical Milford | NCI Medical Clinic | NCI Medical Topeka |
|---|---|---|
| 112 South Main Street | ncimedical.com | 128 Roy Street |
| Milford, IN 46542 | P: 574-832-6246 | Topeka, IN 46571 |
| F: 574-832-2001 | | F: 574-832-2014 |


**PERSONAL REPRESENTATIVE FORM**

Patient Name: _______________________________________________ Date of Birth: _______________

I designate the following person(s) as a personal representative, to have access to my protected health information. This authorization shall be in effect until I notify NCI Medical's Privacy Officer of any such changes.

1. Name: ____________________________________________________________________

   Relationship to you: __________________________ Their Date of Birth: ______________

2. Name: ____________________________________________________________________

   Relationship to you: __________________________ Their Date of Birth: ______________

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I give permission to leave confidential and/or protected health information on my answering machine voicemail.

Circle One: YES NO Initials: _____________

Phone Number: __________________________ Phone Number: _______________________________

**I understand that I may revoke this privilege at any time by submitting my request to NCIMC.**

______________________________________________________________ ____________________

Patient Signature (or responsible party/guardian if minor) Date

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I give North Central Indiana Medical Clinic LLC permission to request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

I consent to the above agreement: YES NO

Patient Signature: _____________________________________________________ Date: _____________

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**PLEASE INITIAL AND VERIFY ANY CHANGES TO YOUR PERSONAL REPRESENTATIVE FORM**

________ No Changes Date _________ ________ No Changes Date _________

________ No Changes Date _________ ________ No Changes Date _________

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**TERMINATION OF PERSONAL REPRESENTATIVE REQUEST**

Patient Signature: _____________________________________________________ Date: ____________

Employee Initials: ____________