

EASTON FAMILY PRACTICE  
1901 HAY TERRACE  
SUITE # 5  
EASTON, PA 18042

**DESIGNATION OF PERSONAL REPRESENTATIVE**

ACCORDING TO GHHA POLICY, EACH PATIENT MUST DESIGNATE A SINGLE  
CONTACT PERSON WITH WOM NURSING NAD MEDICAL STAFF MAY  
DISCUSS YOUR CONDITION AND CARE ISSUES.

I appoint \_\_\_\_\_ as my personal representative for  
discussion of my care. Their contact number(s) are as follows:

\_\_\_\_\_ HOME \_\_\_\_\_ WORK  
\_\_\_\_\_ OTHER

\_\_\_ This person has also been designated as my Emergency contact.

\_\_\_ My care information may also be shared with my Durable Power of Attorney.

\_\_\_ I place no restrictions on disclosure of information regarding my condition. (Anyone  
calling and identifying your by name will be provided with general condition  
information.)

\_\_\_ I request no information concerning my condition or care be released to anyone other  
than my personal representative, if identified above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date