NOVI INTERNAL MEDICINE AND PEDIATRICS, PLLC
Louis W. Schwartz, DO, PLLC
39475 Lewis Drive, Suite 130
Novi, Michigan 48377
Office: (248) 374-0502 Fax: (248) 374-0567

When Your Doctor Needs To Contact You, But You are Not Available

As required by HIPAA (Health Information Portability and Accountability Act) you have a right to nominate one or more persons to act on your behalf of receiving information with respect to your health information that pertains to you. By completing this form you are informing us of your wish to designate the name or names of individuals and telephone numbers where we can leave detailed information about your health care concerns. These individuals can be your spouse, family member or friend. By completing this form you are informing us of your with to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form.

Authorization Section

I designate the following person(s) to receive information about my health care and act as my personal representative with the use and/or disclosure of health information pertaining to me.

1)_____
Print Last Name First Name Telephone Number Other Telephone

2)_____
Print Last Name First Name Telephone Number Other Telephone

The authority of this/these person(s) when acting as my personal representative is restricted to the following functions:_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy.

_____
Signature Date

Revocation Section

I hereby revoke this designation of a personal representative.

_____
Signature Date

Authorization to Leave Messages on Voice Mail/Machines

I acknowledge that it is my right to refuse detailed messages from my physician or physician's office staff regarding my medical care are left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

_____
☐ Yes, please leave me a message Alternate Phone Number Date

_____
☐ No, don't leave any specific messages Date

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When Your Child Needs To See The Doctor, But You Cannot Be There

Anytime you cannot come to the doctor's office with your child, be sure you send the child to the doctor's office with an adult (19 years and older), and give that adult written permission to get treatment for your child.

By law, a doctor cannot treat a child, except in life or death situations, unless the parent or guardian gives consent. Your child's care, or immunizations, could be needlessly delayed because you cannot get to the office. Therefore, if you cannot come to the office with your child, make sure that the adult that brings your child to the office can make medical decisions for your child.

Your child might have a croupy cough and fever. The doctor might want to run a blood test and your child might need a shot. If you are not there, and the adult who brings your child does not have your permission to allow the doctor to run the test or get the shot, your child's treatment will be delayed. You can avoid this by making sure that the adult caregiver has the proper written consent to make medical decisions for your child. You may revoke this designation at any time by signing and dating the revocation of your copy of this form.

Outpatient Treatment Permit/Authorization

1)_____
Print Last Name First Name Middle Initial Date of Birth

The undersigned does hereby grant to the individuals listed below (name of two adult individuals who will be responsible for the care of your child or children in your absence) the limited Power of Attorney to act for me and to give the required consents and authorizations for delivery of medical care, diagnoses and treatment, if necessary from_____ (today's date) and to do all other necessary things as I might or could do if personally present, to include but not limited to:

- Health maintenance visits (routine and immunizations)
- Acute illness (outpatient care and treatment)
- Routine office procedures (x-rays, blood tests, etc.)

A)_____
Name of Responsible Adult Phone Number

B)_____
Name of Responsible Adult Phone Number

_____
Signature of Parent or Legal Guardian Relationship to Child/ren

_____
Address, City, State, Zip Code Telephone Number

_____
Witnessed by Employee of Novi Internal Medicine and Pediatrics, PLLC, Louis W. Schwartz, DO, PLLC *Date*

Revocation Section

I hereby revoke this designation of a personal representative.

_____
Signature Date