Re: Personal Designation Form

Dear Patient (18 years or older):

Thank you for choosing or continuing your care with Children’s Dermatology Services. Due to the federal HIPPA standards, in order for you parent/guardian to have access to your medical records at our office, and to schedule future appointments for you, we are required to have on file the completed attached Personal Representative Designation Form. Please complete this form and mail it to our office or bring it with you at your next appointment.

Thank you,
Douglas Kress, MD
Robin Gehris, MD
Personal Representative Designation Form

This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities: Children's Dermatology Services and Acne Treatment Center

REQUIRED INFORMATION:

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Patient’s Date of Birth:</th>
<th>Patient’s Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name of Patient’s Personal Representative:</th>
<th>Personal Representative Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Representative Address:</td>
<td>Personal Representative Fax:</td>
</tr>
</tbody>
</table>

Any limitations on issues your personal representative may discuss? Yes _____ No _____
If yes, please specify:

Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).

REQUIRED SIGNATURES:

Personal Representative Signature: __________________________ Date: ______________

Patient Signature: __________________________ Date: ______________

Please return this completed form by mail to: Children's Dermatology Services and Acne Treatment Center
Pine Center, Suite 108
11279 Perry Highway
Wexford, PA 15090

or by fax to: 724-933-9194

Form Number (rev.12/2012)