AUTHORIZED REPRESENTIVE FORM

Note: This form is used to confirm a Patient's permission that the health provider may discuss or disclose their Protected Health Information to a particular person who acts as their Authorized Representative. Use of the Protected Health Information is strictly limited to that purpose.

SECTION A: PATIENT INFORMATION

By signing this form in section E below, I understand and agree that ____________________
("Provider") may release my Personal Health Information (PHI) as defined in Section B below to my Authorized Representative named in Section C.

Patient Name: ____

Address: ____

Telephone Number: ______________________________ Chart No: ______________

Please Note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative or if you want to set up a living will or power of attorney, please discuss this with your attorney or health care provider. Also, the provider will not condition treatment, benefits payments, enrollment or eligibility for benefits on the execution of this form.

SECTION B: TYPE OF INFORMATION

*Personal Health Information (PHI), including, but not limited to, identification of treating providers of care, diagnosis, procedures, demographic information.

*This information may include diagnosis and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnosis and/or treatment; and diagnosis and/or treatment relating to other communicable diseases.

*This authorization does not cover disclosure of psychotherapy notes.

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular healthcare provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure: ____

____

____

SECTION C: AUTHORIZED USE AND /OR DISCLOSURE; AUTHORIZED REPRESENTATIVE

I understand that the Provider's general policy is not to disclose my Personal Health Information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my Personal Health Information to the person(s) named below for the purpose of assisting with, facilitating the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to Federal or applicable state privacy laws, my Personal Health Information may no longer be protected by those privacy laws and my Personal Health Representative may further disclose my Personal Health Information without my authorization. I acknowledge that my authorization is voluntary

AUTHORIZED REPRESENTATIVE #1

Name: ______________________________ Relationship to patient: ______________________

Phone Number: ______________________________

Address: ____

AUTHORIZED REPRESENTATIVE #2

Name: ______________________________ Relationship to patient: ______________________

Phone Number: ______________________________

Address: ____

SECTION D: EXPIRATION AND REVOCATION

This authorization to release information to my Authorized Representative will automatically expire two (2) years following the last treatment provided by you to me.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization in writing by giving notice of my decision to the Provider listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon authorization before you actually received my request to revoke it.

Contact Person: ______________________________

Address: ____

Telephone No: ______________________________ Fax: ______________________________

SECTION E: SIGNATURE / AUTHORIZATION

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request of the provider. I understand that, by signing this form, I am confirming my authorization that the provider may use and/or disclose my Personal Health Information to the person(s) named in Section C for the purpose described above. I also confirm that a facsimile copy of this form is acceptable.

Patient Signature: ____ Date: ____________________