

**PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL
RELEASE FORM**

I authorize this facility to speak to the following family members or my personal representative regarding (check one):

All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other medical information in my file.

Only the following types of information:

The above medical information shall only be released to the following persons:

<u>Family Member/Personal Representative</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

Until revoked in writing.

Until _____, 20__.

I know that I am entitled to receive a copy of this agreement.

Printed Name _____

Signature _____

Date _____

HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____ Date: _____

Printed Name of Patient or Legal Representative Witness: _____