PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

FMC Medical Clinic - Fayette (FMC)

Please print all information, then sign, date and time form at bottom.

Name of Practice: _____

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____
2. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____
3. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____
4. Name of Personal Representative _____
   Address/Phone: _____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other _____

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative, including but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Secure Communication -- Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

Signature of Patient (Parent or Legal Guardian)

Date/Time

Copies of signed authorizations are available upon request.