



## Patient Authorization for Personal Representative

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

**Patient Name:**

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**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:

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Name of Personal Representative

Phone

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Address

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City, State, Zip

\_\_\_\_\_ Please designate this person as my Emergency Contact

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **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. This can be done in-person or by mailing a request to: Health First Physicians, 4700 Smith Road, Suite A, Cincinnati, OH 45212.

**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.

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Signature of Patient or Legal Representative

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Date