Authorization for Release of PHI to Others

(For individuals directly involved in the patient's care or payment for care)

I_____, authorize the following persons(s) (spouse, partner, sibling, child, friend, etc.) access to my private health information (PHI).

Name (Printed)_____ Relationship_____ Date of Birth_____ Phone Number (_____)_____
Name (Printed)_____ Relationship_____ Date of Birth_____ Phone Number (_____)_____
Name (Printed)_____ Relationship_____ Date of Birth_____ Phone Number (_____)_____

I understand that these persons are authorized to access my information until that authorization is revoked. Authorization can be revoked verbally or in writing at any time by me (patient) or an appointed Durable Health Care Power of Attorney.

Signature of Patient_____

Name (Printed)_____ Date_____

<u>Personal Representative</u> (Only fill out if there is one of the legal documents below)

I_____, attest that I can act on behalf of _____ (patient) for purposes of treatment authorization and or Use and Disclosure of the patients PHI through rights afforded to me by the state. I will provide all legal documentation required to support the above statement. (Please attach legal documentation to this form).

Examples:

- Durable Power of Attorney for Health Care
- Health Care Proxy
- Court-Appointed Guardian
- Letters of Testamentary/Administration

Signature_____

Name (Printed)_____Date_____