7.30

Patient Authorization for Personal Representative

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

Type of Authorization: Personal Representative

Patient Name (please print)_____

Purpose of request - I authorize **A+ Family Medicine** to disclose 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, they may exercise my right to inspect, copy, and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

_____

Name of Personal Representative Relationship

_____

Address

_____

City, State, Zip

_____

Phone

Description of information to be disclosed - I authorize **A+ Family Medicine** 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.

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 A+ Family Medicine.

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:

A+ Family Medicine, PC
2849 Michigan Street NE Suite 102
Grand Rapids, MI 49506
Attn: Privacy Manager

_____ _____

patient signature date