

Personal Representative Authorization Release Form
Health Information Protected Under HIPAA

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

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

Only the following types of information: _____

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

<i>Name of Personal Representative</i>	<i>Relationship</i>	<i>DOB</i>	<i>Phone #</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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____

Name: _____

Signature: _____

Date: _____

Office use only

Witness: _____
Scan Initials: _____