

PRIMED PHYSICIANS

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) _____ **Date of Birth** _____

Purpose of request – I authorize PriMed Physicians 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, they may exercise my right to inspect, copy, and correct my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Personal Representative

Address

City, State, Zip

Phone

Description of information to be disclosed – I authorize PriMed Physicians 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 to our Privacy Manager. This can be done in person or by mailing a request to:

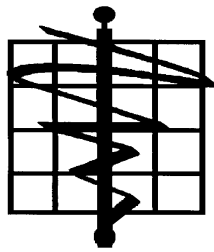
PriMed Physicians
6529 Acro Court
Centerville, OH 45459

Attn: Privacy Manager

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 PriMed Physicians. _____

Patient Signature

Date



PRIMED PHYSICIANS

7.31 Patient Authorization for Disclosure of Protected Health Information

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

Type of Authorization: Release of protected health information to a designated person.

Patient Name (please print) _____

Purpose of request – I authorize PriMed Physicians to disclose or provide protected health information, about me, to (please identify person or persons who will receive the information):

Description of information to be disclosed – I authorize PriMed Physicians to disclose the following protected health information about me to the person identified above (please provide a written description of the information to be disclosed):

Purpose of disclosure – (please list the purpose of the disclosure):

Expirations or termination of authorization – This authorization will expire at the end of the calendar year in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): _____

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:

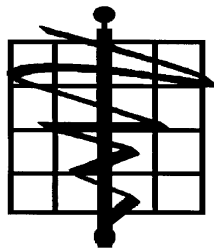
PriMed Physicians
4700 Smith Road, Suite A
Cincinnati, OH 45212

Attn: Privacy Manager

Redisclosure – We have no control over the person(s) you have listed to receive your protected health information. 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 PriMed Physicians.

Patient Signature

Date



PRIMED PHYSICIANS

7.32 Patient Authorization for Disclosure to Designated Provider

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

Type of Authorization: Designated Provider

Charge _____

Patient Name _____

Patient Social Security Number _____ Patient Date of Birth _____

Purpose of request – I request and authorize the disclosure or release of my protected health information (as identified below) to the following provider:

Provider Receiving Records	Provider Releasing Records
Name of practice	Name of practice
Name of provider	Name of provider
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone

Description of information to be disclosed – I authorize the disclosure of the following protected health information about me to the person(s) identified above:

___ Complete medical record; or ___ Only the following information:

Purpose of disclosure – This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

___ Patient Request

- **Expirations or termination of authorization** – This authorization will expire within 14 days from the date of my signature below.
- **Right to revoke or terminate:** As stated in our Notice Privacy Practices, you have the right to revoke or terminate this authorization.
- **Redisclosure:** We have no control over the person(s) you have listed to receive your protected health information. 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.
- **No conditions:** Your signature on this authorization does not condition your treatment, payment or eligibility for benefits.

Patient or Responsible Party Signature

Date