

# AUTHORIZED REPRESENTATIVE FORM

## INSTRUCTIONS:

Please complete this form if you wish to name another person(s) who may speak to us about your health, account, appointment, or other interactions with our practice. **If you do not complete this form, no one—other than you—can speak to us about your association with our practice.**

## REQUESTOR'S INFORMATION:

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

By signing this form below, I understand and agree that *I.D. Consultants, P.A. and Infusion Care Specialists* (IDC) may release my personal health information to the Authorized Representative(s) I name below. Personal Health Information is defined as identification of treating providers of care, demographic information, procedures, and personal diagnoses, **including HIV, AIDS, cancer, sexually transmitted diseases, alcohol- and drug-related conditions, as well as psychotherapy notes or notes regarding my mental status.**

I understand that this authorization does not provide my Authorized Representative with any authority, either implied or direct, over any treatment or direct-care decisions.

## AUTHORIZED USE/ DISCLOSURE:

I understand that IDC's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize IDC to discuss and disclose my personal health information to the person(s) named below. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge my authorization is voluntary.

## Authorized Representative # 1:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship to You \_\_\_\_\_

## Authorized Representative # 2:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship to You \_\_\_\_\_

## SIGNATURE/ AUTHORIZATION:

I understand that by signing this form, I am confirming my authorization that IDC may use and /or disclose my personal health information to the person(s) name as Authorized Representative(s). This authorization will expire only upon my written revocation.

Signature \_\_\_\_\_ Date \_\_\_\_\_