

Patient Instructions for Form 7.30 – Patient Authorization for a Personal Representative

Your authorization for a Personal Representative will give our office the authority to provide access and other rights to your health information for the person you have authority to provide access and other rights to your health information for the person you have designated to be your Personal Representative. If you wish to designate a Personal Representative, Form 7.30 must be completed and signed by you, and will be maintained as part of your medical record.

Your Personal Representative will have all the rights to your health information you have under the privacy rule. This means your Personal Representative will have the right to access and review your health information, the right to appoint more Personal Representatives, the right to request restrictions and amendments to your health information, and the right to obtain an accounting of disclosures we have made regarding your health information.

A Personal Representative does not have the authority to make healthcare decisions on your behalf.

The following outline will help to explain what information we will need on the form and its purpose. Please address any questions with our staff.

Name of practice - list the name of our practice if it is not already on the form.

Patient name - Print your name.

Social security number and date of birth - This information is needed for identity verification and is maintained in a confidential manner at all times.

Purpose of request - You must print the name of the person you want to be your Personal Representative along with his or her phone number and address so we may contact him or her if necessary.

Description of information be disclosed - A Personal Representative has the right to access and be informed of all your health information. Should you wish to limit the information to which he or she will have access, we will instead provide you with a limited patient authorization form for your use.

Expiration of termination - This authorization will remain in effect until you or your Personal Representative or someone with legal authority, chooses to request termination of the authorization.

Right to revoke or terminate - You may revoke or terminate this authorization at any time by contacting our privacy manager. Requests for revocation or termination must be made in writing.

Redisclosure statement - We cannot be responsible for what your Personal Representative does with your health information provided under this authorization. The redisclosure statement simply informs you of this situation.

Signature and date - We will need your signature and date to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.



Authorize Personal Representative



Patient Authorization for Personal Representative

Name of Practice: _____

Patient Name: _____

Social Security Number: _____

Purpose of request: I authorized the practice 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, he or she may exercise my right to inspect, copy, and request amendments to my Protected health information. He or she may also consent to authorize the use or disclosure of my protected health information:

Name of Personal Representative: _____

Phone: () - _____

Address: _____

City, St Zip: _____

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated Personal Representative.
- **Explorations or termination of authorization:** this authorization will remain in effect until terminated by you, your Personal Representative, or another individual(s) or 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 the address below.

Pinnacle Care Providers, LLC
236 3rd St SW
Canton, OH 44702
Attn: Privacy Manager

Redisclosure: we have no control over the person 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 this practice.

Patient Name: _____

Signature: _____

Date: _____