

Patient Authorization to allow personal representative to discuss or review medical records

Patient Information:

Name of Patient: _____ **Date of Birth:** _____

Name & Address of Patient authorized to release information:

Name & Address of Patient Representative to discuss/review information:

Description of information to be discuss/reviewed at the request of the patient:

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

_____ Date:

Signature of Patient or Personal Representative

Print or Type Name of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)