FAIRFIELD MEDICAL CENTER

Lancaster, Ohio

PERSONAL REPRESENTATIVE AUTHORIZATION

PATIENT LABEL

Dear Patient,

The privacy of your healthcare information is important to us. Federal law gives you the right to choose one or more persons to act on your behalf with respect to the health information that pertains to you. By completing this form, you are telling Fairfield Medical Center (FMC) that the named person(s) you would like to designate as your Personal Representative(s). This form also grants FMC (the provider), permission to discuss or disclose Protected Health Information (PHI) to the designated person who acts as the patient's Personal Representative(s) (as defined by OCR HIPAA Privacy 45 CFR 164.502(g)).

Section A: PATIENT INFORMATION

By signing this authorization in Section E below, I understand and agree that Fairfield Medical Center (FMC) may release my personal health information to my Personal Representative(s) named in Section D below.

Your Name: (Print) _____
(Last) (First) (Middle)

Home Address: _____

Telephone Number: _____ Date of Birth: _____

Signature: _____

Please Note: This authorization does not provide your "Personal Representative" with any authority; either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy, clinical personal healthcare representative, or if you want to set up a Durable Healthcare Power of Attorney, please discuss this with your primary care physician, attorney, or a FMC Patient Representative. I UNDERSTAND THAT I DO NOT NEED TO SIGN THIS FORM TO ENSURE HEALTHCARE TREATMENT.

Section B: TYPE OF INFORMATION

Information which will be available to the Personal Representative(s) includes, but is not limited to, identification of treating providers of care, diagnoses, testing results, procedures, and demographic information. Information disclosed may also include information regarding developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS; however excludes disclosure of mental health or psychotherapy notes.

Please check all applicable items:

___The right to access the patient portal.
___The right to communicate about scheduled appointments/procedures, schedule, and/or change appointments.
___Access medical records or other protected health information.
___The right to communicate with my health care team.
___Other (please specify)

_____

_____

Section C: EXPIRATION AND REVOCATION:

This authorization to release information to my Personal Representative(s) has no expiration date. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at Fairfield Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Patient Initial _____

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Section D: AUTHORIZED USE AND/OR DISCLOSURE

Intended Use or Disclosure:

I understand that it is not the general policy of FMC 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 you to discuss and disclose my personal health information to the person(s) named below. I also understand that if my Personal Representative(s) is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my personal health information, and my Personal Representative(s)may futher disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Personal Representative #1:

Name: _____ Phone Number: _____

Address: _____

Relationship to you: _____

Email: _____

Personal Representative #2:

Name: _____ Phone Number: _____

Address: _____

Relationship to you: _____

Email: _____

Section E: SIGNATURE/AUTHORIZATION:

I have had full opportunity to read and consider the content of this Personal Representative Authorization Form. I confirm that this authorization is consistent with my request of Fairfield Medical Center. I understand that, by signing this form, I am confirming my authorization that Fairfield Medical Center may use and/or disclose my personal health information to the person(s) named in Section D for the purpose described above.

_____ _____ _____

Signature Date Time

Instructions: Complete each section. This form must be filled out completely. Mail, fax, or deliver to:

Fairfield Medical Center
Medical Records
401 N Ewing Street
Lancaster, Ohio 43130
Fax 740-687-8935