East Liberty
Family Health Care Center
A CHRISTIAN MINISTRY OF
WHOLE PERSON HEALTH CARE

# EAST LIBERTY FAMILY HEALTH CARE CENTER
# PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone: _____ Social Security No: _____

**Purpose of request:**

I authorize the following:

East Liberty Family Health Care Center
7157 Mary Peck Bond Place
Attn: Medical Records
Pittsburgh, PA 15206
Phone: 412-661-2802
Fax: 412- 661-8020

to disclose or provide my/my child's protected health information to the following individual who is authorized to act as my/my child's personal representative for the purposes of receiving protected health information about myself/my child. As my/my child's personal representative, he/she can (initial all that apply):

____ Make appointments for health care services
____ Have discussions with health care providers about routine tests and treatments (that do not require informed consent)
____ Access medical information, as necessary, to have discussions with health care providers about routine tests and treatment.
____ Discuss billing and insurance concerns.

As the personal representative for a minor child, he/she can (initial all that apply):

____ Accompany my minor child to East Liberty Family Health Care Center for appointments.
____ Make decisions of a routine nature as determined by the discretion of East Liberty Family Health Care Center health care provider serving my child during an appointment.

Note: **This form is not applicable and cannot be used to disclose behavioral health treatment, drug/alcohol treatment, and communicable diseases information or when major health care decisions are involved.**

_____ _____
Name of Patient's Personal Representative Personal Representative Phone Number

_____
Personal Representative Address

**Expiration or termination of authorization**: This Authorization will remain in effect until terminated by you or if the patient is a minor, when the patient turns 18 years of age.

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**Right to Revoke or terminate**: You have the right to revoke or terminate this authorization by submitting a written request. Please contact the East Liberty Family Health Care Center Medical Record Department at the above listed phone number for instructions on revoking this authorization.

**Redisclosure:** East Liberty Family Health Care Center has no control over the individual(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 this practice.

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Guardian/Legal Representative Date

_____
Printed Name of Legal Guardian/Legal Representative

**Basis of Authority of Legal Guardian/Legal Representative**
If you are the Legal Guardian/Legal Representative who provided written authorization, please check the basis for the authority.

__ Parent of Minor ___ Guardianship Order (copy attached)
__ Power of Attorney (copy attached) ___ Other, please specify_____

## REVOCATION OF PERSONAL REPRESENTATIVE

I, _____, hereby revoke the authorization for
*Printed Name of Patient/Legal Guardian/Legal Representative*

personal representative, I provided to East Liberty Family Health Care Center, which I signed on_____ appointing _____. I understand that this revocation does not apply to any action that East Liberty Family Health Care Center has taken in reliance on the authorization that I have signed earlier.
*Date* *Name of Appointed Personal Representative*

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Guardian/Legal Representative Date

_____
Printed Name of Legal Guardian/Legal Representative