The Family Practice & Orthopedic Care Center, PC
Omega Physical Therapy
Hillsdale Sports Medicine

Patient Authorization for Personal Representative
Release & Consent of Health Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____-_____-_____

Purpose of Request: *I authorize the practice to disclose or provide my protected health information to the following individual(s) 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/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclose of my protected health information:*

_____

Name of Personal Representative **Phone Number**

_____

Address **City, State** **Zip**

- **Description of information to be disclosed**: I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization**: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of 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 Practice Administrator. This can be done in person or by mailing request to:

  The Family Practice & Orthopedic Care Center, PC
  Attn: Practice Administrator
  410 N. Willowbrook Road, Coldwater, MI 49036

Redisclosure: We have no control over the person(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**