

APPENDIX G-2

Authorization Form to Use and Disclose Protected Health Information (By Authorized Personal Representative)

Patient's name: _____ Date of Birth: _____

Representative's name and address: _____ Relationship: _____

Patient's ID #: _____

On behalf of _____, I hereby voluntarily authorize the use and disclosure of his/her protected health information:

1. Specific Description of the Information to be Used or Disclosed:

The above information will be called "Authorized Information" throughout the rest of this form.

2. Person (or class of persons) Authorized to Make the Use or Disclosure of Authorized Information:

3. Person (or class of persons) to Whom the Use or Disclosure of Authorized Information May Be Made:

4. Authorized information will be used and/or disclosed for the following purpose(s):

5. This authorization expires: _____

6. Furthermore, by signing below, I understand that:

- the personal information will be released to the person or persons listed in number 3 above;
- this information may include information regarding mental health, drugs & alcohol, HIV/AIDS and other communicable diseases, and/or genetic testing (unless specifically excluded above);
- I may revoke this authorization by a written notification of my desire to revoke it to the medical provider named in number 2 above;
- any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
- the medical provider named in number 2 above may not condition treatment of _____ on whether or not I sign this authorization; and
- information released may no longer be protected by federal privacy regulations.

Personal Representative's signature _____ Date: _____