RIVERLAND COMMUNITY HEALTH

Authorization for Family Member or Appointed Person

Name of Patient: **DOB:**

Address: **Previous Names:**

I authorize my Protected Health Information to be released/ shared with:

Name:_____ Relationship to Patient_____

Name:_____ Relationship to Patient_____

Name:_____ Relationship to Patient_____

Name:_____ Relationship to Patient_____

The individual(s) named above is authorized to obtain information in the following manner:

☐Verbally: via phone call or in person

☐Written: printed or electronic format

☐This authorizes the above-named individual(s) to obtain unlimited health information

☐This authorizes the above-named individual(s) to obtain health information pertaining to these limited conditions: _____

☐This authorizes the above-named individual(s) to accompany this patient to appointments and authorize treatment.

I understand the information to be released may include my past, present or future health information. I may revoke this authorization at any time. This authorization will not expire unless revoked by myself or my legal representative upon notification of death. I understand that information disclosed pursuant to this authorization might be disclosed by the recipient and may no longer be protected by HIPAA.

Printed
Name:_____Date_____

Patient Signature or Authorized person's signature

Authorized person's authority:

(Parent, Guardian, Power of Attorney): _____