Patient Authorization for Personal Representative

Purpose of request -1 authorize Generations Primary Care, PSC to disclose or provide all of my protected health information to the following individual 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, they may exercise my right to inspect, copy, and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

Expirations or termination of authorization - Right to revoke or terminate - This authorization will remain in effect until terminated by you, your personal representative or another individual(s) or legal entity authorized to do so by court order or law. 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 Privacy Manager.

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 Generations Primary Care, PSC.

Patient Name _____Date _____

Patient Signature _____

Personal Representative Name _____

Address _____

Phone Number _____

Consent for Blood Sample and Testing

I give consent that in the event an employee of Generations Primary Care, PSC should be exposed to my blood a sample of my blood will be tested for hepatitis B, hepatitis C and HIV. I understand that the blood sample will be sent out to a laboratory for testing, and that the test results will be released directly to the exposed employee. I further understand that the test results will NOT be released to any other individual in the practice, including owners, physicians, management and other employees. The exposed employee will hold the test results confidential; consulting only with the healthcare professional that is conducting the follow-up evaluation for the incident. Generations Primary Care, PSC will absorb the cost for the testing.

Patient Name_____Date of Birth _____

Signature_____Date _____