Patient Authorization for Personal Representative

Purpose of request -I 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 other 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 (Please Print) _____Date of Birth_____

Patient/Guarantor Signature_____ _____ Date_____

____ I DO NOT choose to authorize any individual to act as my personal representative.

____ I choose to authorize the following individual(s) to act as my personal representative:

(Please Print)
Personal Representative Name_____

Address_____

Phone Number_____

(Please Print)
Personal Representative Name_____

Address_____

Phone Number_____

(Please Print)
Personal Representative Name_____

Address_____

Phone Number_____