Patient Authorization for Personal Representative

You may give **Parkwood Pediatric Group** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient Name: ____________________________________Date of Birth:___/____/______

Date:____/____/______ Account #:______________________________Chart #:________________

At my request, I authorize **Parkwood Pediatric Group** to disclose my protected health information to:

Name:_____________________________________Phone #:___________________________

Name:_____________________________________Phone #:___________________________

Name:_____________________________________Phone #:___________________________

At my request, I also authorize **Parkwood Pediatric Group** to communicate my protected health information to me via the following methods:

☐Leave detailed message on my home answering machine (phone #:_______________)

☐Leave detailed message on my voice mail at work (phone #:______________________)

☐Leave detailed message on my cell phone voice mail (phone #:___________________)

☐Fax detailed medical information (fax #:_______________________________)

☐E-mail detailed medical information (e-mail:_____________________________________)

Authorized Signature:____Date:_____________

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Parkwood Pediatric Group** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation:____

Date Authorization Cancelled: ____/____/______

Form 10DPR Maintain a copy of the Designated Release Form with the administrative documents section of the patients medical record.