East West Pediatrics, LLC
HIPPA Privacy Rule
Personal Representative Authorization

Patient Name _____ Date of birth _____

Section A --Purpose
This form allows you (the "individual") to give East West Pediatrics permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care, diagnoses, procedures, and personal information, such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older, or as determined by state law) who expects to have a relative or friend act as a Personal Representative must complete an authorization form. For example, if you expect your parent to call us on your behalf, you need to fill out this form. If you do not wish to name a personal representative, do not complete this form. You are not required to name a personal representative, but if you do not, we will not release you protected health information to someone who might call or write on your behalf. Your Personal Representative may be anyone of your choosing. You must provide the information in section C for each person before we can treat that person as your Personal Representative.

Please Note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions.

Section B—Individual's information
I authorize East West Pediatrics to treat the person(s) named in Section C as my Personal Representative(s) subject to the rights and restrictions, if any described in Section C.

My name _____ Date of Birth _____

Daytime phone _____ Relationship to Patient _____

Section C ---Authorized Use or Disclosure

I understand that East West Pediatrics' privacy practice is not to disclose my personal health information, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named in Section C. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis or disease. Any such limitations must be described in Restrictions, in this section.

Personal Representative #1

Full Name _____ Phone Number _____

Relationship to You _____(e.g. Parent, spouse, friend,etc.)

Restrictions:

_____

_____

_____

Personal Representative #2

Full Name _____ Phone Number _____

Relationship to You _____(e.g. Parent, spouse, friend, etc.)

Restrictions: _____

Section D –Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire two (2) years after the date it is signed.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named in Section C to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Official at the address shown below. I understand that my revocation of this authorization will not affect any action that you have taken of information that you have already released, based upon the authorization, before you receive my request to revoke authorization.

Naomi Shaikh, M.D.
1600 S. Crain Hwy, Suite 207
Glen Burnie, MD 21061

Section E – Signature / Authorization

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that East West Pediatrics may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature _____ Date: _____