MARK P. SERALY M.D.,P.C.

Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Name of Practice: **MARK P. SERALY, M.D., P.C.**

Patient Name: _____

Date of Birth: _____

Purpose of request: I authorize the practice to disclose or provide 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 designate personal representative, he/she may exercise my right to inspect, copy and request amendments to my protected health information. He /she may also consent or authorize the use or disclosure of my protected health information:

_____

Name Relationship

_____

Name Relationship

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 this practice.

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Patient Authorization for Disclosure of Protected Health Information Via Alternate Means

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, "by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care." The practice requires the following authorization of release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

_____ Cell Phone _____Email Address _____US Mail _____Home Phone

_____

Patient Signature Date

Copies of signed authorizations are available upon request.