Appointment of Personal Representative

Patient Name: ____ Date of Birth: ________________

Purpose:

This form allows you (Parent and/or legal guardian) to give Southwest Children's Clinic permission (authorization) to disclose your child's 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 child (age 18 or older) who wishes to name a Personal Representative must complete an authorization from. For example if you expect your spouse 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 your child's protected health information to someone who may call or write on you or your child's behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, adult child, friend, congressperson or union representative. If you need additional forms, you may copy this form or call us.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions. This authorization is required for Personal Representatives to receive lab or x-ray results, pick up prescriptions, school forms or vaccine records, or accompany your child to appointments.

Authorization Use and/or Disclosure:

I understand that Southwest Children's Clinic's privacy practice is not to disclose my child's 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 child's protected health information to the person(s) listed below for the purpose of assisting with or facilitating my child's health care and payment of any health benefits. Unless I have stated otherwise in Restrictions, I also allow my Personal Representative the following rights: the right to request amendment of my child's PHI; the right to request an accounting of disclosures of my child's PHI; and the right to request restrictions on disclosure of my child's PHI. I understand that if my Personal Representative is not a health plan, a health care provider, or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my child's personal health information, and my Personal Representative may further disclose my child's protected health information without my authorization. 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; I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in Restrictions in this section.

Personal Representative 1(please print clearly) **SOMEONE OTHER THAN PARENT

Full Name:____________________________________ Phone Number: _____________________________________

Relationship to patient/child: ___________________________ (such as: step parent, sibling, grandparent, etc.)

Restrictions: ____

Personal Representative 2 (please print clearly) **SOMEONE OTHER THAN PARENT

Full Name:_____________________________________ Phone Number: _____________________________________

Relationship to patient/child: ___________________________ (such as: step parent, sibling, grandparent, etc.)

Restrictions: ____

This authorization to release information to my Personal Representative will automatically expire in three (3) years from the date of my last visit to Southwest Children's Clinic.

I understand I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named above 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 has been taken or information that has already been released, based upon this authorization, before receiving my request to revoke authorization.

Southwest Children's Clinic
8822 S Redwood Road, Suite C211
West Jordan, UT 84088

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 Southwest Children's Clinic may disclose my child's protected health information to the person(s) named on this form, for the purpose described above.

Signature: ____ Date: ____________________

(Parent/legal guardian)

*If you do not wish to appoint anyone as a representative, please sign this form anyway!

Updated August 2017