PERSONAL REPRESENTATIVE AUTHORIZATION FORM

Health Information Management

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Ph: 360-642-6356 Fax: 360-412-6484

The Personal Representative Authorization Form is used to identify the person(s) who are permitted to have the same rights that you have to access your confidential protected health information including Special Authorizations. By signing this form, you are allowing Ocean Beach Hospital & Medical Clinics (OBHMC) to release protected health information to the individual(s) named. Your signature also releases OBHMC from any liability of any nature in connection with the release of your protected health information provided that the terms detailed in this form are followed. OBHMC is not responsible for any use, misuse or secondary release of information by the individual(s) listed below.

PATIENT INFORMATION

Please Print

Last Name	First	Middle	Date of Birth

DESIGNATED REPRESENTATIVE INFORMATION

Last Name First Middle	Relationship to Patient
Street Address or PO Box	Daytime Phone
City, State, Zip	Evening Phone

This authorization expires one year from the date of signing unless revoked or otherwise specified: ____________________

At the time of expiration, a new authorization must be completed in order to be valid. You may cancel this authorization in writing any time.

____ ____________________

Signature of Patient Date

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Witness/Ocean Beach Hospital Employee