Personal Representative Form

Important Information about Personal Representatives

The HIPAA Privacy Rule requires **[FACILITY]** to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care.

You have the right to authorize that the PHI held by **[FACILITY]** be released to and/or received by persons or organizations you identify. The person or organization you identify on the Personal Representative Request Form may not be subject to the HIPAA Privacy Rule. If this is the case, your appointed Personal Representative may further release your confidential information without protection from federal or state privacy laws.

Appointing a Personal Representative is voluntary.

[FACILITY] will not treat someone as your Personal Representative if (1) we reasonably believe you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), we decide that it is not in your best interest to treat the person as your Personal Representative.

To assist **[FACILITY]** in responding to your request to appoint a Personal Representative, please complete the following form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. If you are giving permission to **[FACILITY]** to share the PHI of your minor child(ren), please complete the applicable section of the form below.

Please email the completed form to: facilityemail@tenethealth.com

or

Mail or fax the completed form and supporting documentation to:

[FACILITY]
Street Address
City, State, Zip
Fax: (123) 456-7890

If you have any questions about his form, please contact **[FACILITY]** at (123) 456-7890.

Please complete and sign this form to appoint a personal representative. **[FACILITY]** will provide your appointed personal representative the same rights to your Protected Health Information (PHI) that are provided to you. **Questions regarding this form should be directed to [FACILITY] at (123) 456-7890.**

Personal Representative Form

PATIENT INFORMATION		
Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	
Address (Street, City, State, Zip):	Home Telephone (include Area Code):	

PERSONAL REPRESENTATIVE INFORMATION		
Name (First, Middle, Last, Title):	Home Telephone (include Area Code):	State Issued Drivers License or ID:
Address (Street, City, State, Zip):	Personal Representative's Relationship to Member:	

IF YOU ARE GRANTING ACCESS TO PHI OF COVERED MINOR CHILD TO ANOTHER PERSON		
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:
Child's Name (First, Middle, Last, Title):	Date of Birth (Month/Day/Year):	Gender:

AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE

1. Please state the purpose of this authorization

☐ To appoint a personal representative to act on my/or my minor children's behalf for decisions related to health care.

☐ Other: For the following purpose (please specify and describe in detail): _____

_____

_____

2. I hereby authorize the request and release of PHI held by **[FACILITY]** to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing **[FACILITY]** to give this person access to PHI, the right to talk to **[FACILITY]** about medical care, and the right to make decisions that will bind me.

3. I represent that the person I am appointing has agreed to act as my/or my minor children's personal representative.
4. I understand that my Personal Representative designation will remain in effect until a court order, an applicable law, or I revoke it.

Patient Signature:	Personal Representative Signature:
Date Signed:	Date Signed: