UNIVERSITY ORTHOPEDICS

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Dear Patient,

Please review and sign the attached paperwork if you would like to have a patient representative through our office. This may include a parent, spouse, health advocate, etc. Please keep in mind that without your signature, NO personal health information can be released to another individual. This includes your appointment times and locations and any information about the care you are receiving. Please understand that this authorization may be revoked in writing at any time, except to the extent of the actions that have already been taken in reliance upon this authorization.

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Patient Representatives

Scope: ALL SITES | P&P#: Patient Representation | Revision date: 6/24/2015

Summary:

PERSONAL REPRESENTATIVES
[45 CFR 164.502(g)]

The HIPAA Privacy Rule establishes a foundation of Federally-protected rights which permit individuals to control certain uses and disclosures of their protected health information. Along with these rights, the Privacy Rule provides individuals with the ability to access and amend this information, and the right to an accounting of certain disclosures. The Department recognizes that there may be times when individuals are legally or otherwise incapable of exercising their rights, or simply choose to designate another to act on their behalf with respect to these rights. Under the Rule, a person authorized (under State or other applicable law, e.g., tribal or military law) to act on behalf of the individual in making health care related decisions is the individual's "personal representative." Section 164.502(g) provides when, and to what extent, the personal representative must be treated as the individual for purposes of the Rule. In addition to these formal designations of a personal representative, the Rule at 45 CFR 164.510(b) addresses situations in which persons are involved in the individual's health care but are not expressly authorized to act on the individual's behalf.

Form follows on Page 2

(Form is all that is required to retain in file;

Patient must receive copy of BOTH pages)

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PATIENT'S NAME: _____ **DOB:** _____

(PLEASE PRINT CLEARLY)

Physician: _____ **Acct#** _____

The patient must read and initial the following statements and the patient must sign on the line indicated below:

1. I authorize _____ to discuss all matters related to the care I am receiving at University Orthopedics. Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions taken prior to the date of the revocation. Initials: _____

_____

Signature of patient Date

_____

PRINT name of pt rep _____

Relationship to patient _____

Contact information for representative:

Phone: _____ Cell phone: _____

(Form MUST be completed before signing)

MSS