AUTHORIZATION FOR SHARING AND RELEASE OF INFORMATION TO PERSONAL REPRESENTATIVES

Descanso Medical Center for Development & Learning
1346 Foothill Boulevard, Suite 301
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818.790.1587
Carole J. Swemline, Privacy Officer

As required by the Health Information Portability and Portability and Accountability Act of 1966 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning

_____

(Name and date of birth of patient)

Health information to be used or disclosed

Name of Personal Representative:

_____

Relationship to Patient:

_____

I authorize the following disclosures to the above-named personal representative:

- ☐ Consent to be present at the office visits
- ☐ Consent to speak to doctor on my behalf
- ☐ Consent to scheduling appointments
- ☐ Consent to picking up my prescriptions
- ☐ Consent to speak about my charges/payments
- ☐ Other _____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

This authorization is effective now and will remain in effect until _____

(Date or Event)

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____