

DESIGNATING A PERSONAL REPRESENTATIVE

Patient Label

Patient Name: _____ DOB: _____ Phone: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____

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You have the right to choose one or more persons to act on your behalf with respect to your Protected Health Information (PHI). PHI includes treatment information about your visit or conditions, medication list, making appointments, lab orders and results, and more. By completing this form, you are letting us know that you authorize your personal representatives to listen/view your protected health information and make treatment decisions on your behalf. It only gives your personal representative access to the information **YOU** allow them to access. Please complete this form in it's entirely so that we may provide you and your representative with the correct information. This form may be revoked at any time.

CCOLE staff may limit information shared with Authorized Representatives to the minimum amount of information necessary to accomplish the intended purpose.

I authorize CommuniCare+OLE to treat the person(s) below as an Authorized Representative on my account:

Name (First and Last):	_____ Dental Records <input type="checkbox"/> Dental Records (Dental History and Visit Information) <input type="checkbox"/> Dental Imaging (X-ray)
Relation to Patient:	_____ Medical Records <input type="checkbox"/> All Personal Health Information (Not including Behavioral Health, Substance Abuse, HIV/AIDS, Sexual Health)
DOB:	<input type="checkbox"/> Specified Records Only: (Please describe): _____ _____
Name (First and Last):	_____ Dental Records <input type="checkbox"/> Dental Records (Dental History and Visit Information) <input type="checkbox"/> Dental Imaging (X-ray)
Relation to Patient:	_____ Medical Records <input type="checkbox"/> All Personal Health Information (Not including Behavioral Health, Substance Abuse, HIV/AIDS, Sexual Health)
DOB:	<input type="checkbox"/> Specified Records Only: (Please describe): _____ _____
Name (First and Last):	_____ Dental Records <input type="checkbox"/> Dental Records (Dental History and Visit Information) <input type="checkbox"/> Dental Imaging (X-ray)
Relation to Patient:	_____ Medical Records <input type="checkbox"/> All Personal Health Information (Not including Behavioral Health, Substance Abuse, HIV/AIDS, Sexual Health)
DOB:	<input type="checkbox"/> Specified Records Only: (Please describe): _____ _____

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NOTE:

Your health record may include information that references HIV/AIDS, alcohol/drug or behavioral/mental health services. The actual treatment records from HIV/AIDS, alcohol/drug, and/or behavioral/mental health will not be disclosed unless specifically requested via a Release of Information Authorization (ROI) Form.

Sensitive Patient Information

- Sexual/Reproductive Health/Gender Affirming Care—Birth control, abortion, STI treatment, gender-related care (CMIA §56.11)
- Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et seq.)
- Information pertaining to Substance Use treatment and counseling (42 CFR Part 2)
- Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- Release of genetic testing information (Health and Safety Code §124980(j))

EXPIRATION:

This authorization shall become effective immediately and shall **remain in effect permanently**, until revoked in writing by me unless a different date is specified here: ____ / ____ / ____.

ACKNOWLEDGEMENTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to any CommuniCare+OLE Health Center site listed below.
- My revocation will be effective upon receipt but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receive a copy of this authorization.
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.

RESTRICTIONS

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

SIGNATURES:

Name (Printed): _____ Signature: _____ Date: _____

If signed by other than the patient, print name and relationship:

Name (Printed): _____ Relationship to Patient: _____

Signature: _____ Date: _____

REVOKE: I understand and acknowledge that revocations/cancellations of this designation shall not apply to information that has already been released or affect actions taken by CCOLE Health prior to this request.

Please sign and date to revoke this authorization: Signature: _____ Date: _____