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Personal Representative(s) Authorization

This form is used to confirm a member's permission that Northeast Medical, P.C. may discuss or disclose your protected health information to a particular person who acts as your Authorized Representative. Use of your information is strictly limited to that purpose described below. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this information at any time by notifying our office in writing.

AUTHORIZATION SECTION

I, _____ (Print Patient Name) Patient's Birthdate: _____
Social Security Number: _____ hereby authorizes the **use and disclosure** of my health information by the physician and employees of Northeast Medical, P.C. to my designated **Personal Representative(s)** below:

My spouse (please specify name) _____

My child (please specify name) _____

My parent(s) (please specify name) _____

My Guardian (please specify name) _____

Other (please specify name) _____

The following health information may be released to the designated Personal Representative(s) listed above:

All medical and billing/financial records

Other _____

The release of my health information to the Personal Representative(s) named above is unlimited with the following exception(s) if any: _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by writing to Dr. T.P. Singh, Northeast Medical, P.C. at 3488 Sheridan Drive, Amherst, NY 14226. I further understand that any such revocation does not apply to the extent that person(s) authorized to use or disclosure my health information has already acted in reliance on this authorization.

I understand that this authorization will not expire unless I revoke it by writing as detailed above.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that I have the right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

Patient Signature

Date

Guardian/Legal Representative Signature: _____

Witness: _____ Date: _____