RELEASE OF INFORMATION TO PERSONAL REPRESENTATIVE

Purpose: This form is used to confirm a patient's permission for Acworth Urgent Care to discuss or disclose their Protected Health Information to a specific person who acts as their Personal Representative. A separate form must be completed for different patients from the same family.

Patient Information: (Read and print clearly)
I understand that my personal health information will be released by Acworth Urgent Care to the individual(s) I appoint as my Personal Representative(s).

Patient Name:____

Telephone Number:_____________________________ **Date of Birth:**_______________

Personal Representative(s): (Read and print clearly)
I authorize the discussion and/or the disclosure of my personal health information with the individual(s) listed below. I understand that it is the policy of Acworth Urgent Care not to release such information to other people, except those directly involved in my care, without my written permission.

Personal Representative Name:____

Telephone Number:______________________________ **Last Four Digits of SS#:**________

Personal Representative Name:____

Telephone Number:______________________________ **Last Four Digits of SS#:**________

Expiration and Revocation
Permission to release my personal health information to the Personal Representative identified above will automatically expire upon termination of care by Acworth Urgent Care.
I understand that I have the right to revoke or discontinue this permission at any time, provided that I notify Acworth Urgent Care in writing.

Signature / Authorization: (Read, sign and date)
With my signature below, I authorize Acworth Urgent Care to discuss and/or disclose my personal health information for the purpose described above to the individual designated as my personal representative.

Patient Signature:______________________________________ **Date:**_______________