DESERET FAMILY MEDICINE

ASSIGNMENT OF PATIENT REPRESENTATIVE

- I hereby authorize the use and disclosure of any protected health information as set forth below.
- I understand that I may revoke this authorization at any time by notifying Deseret Family Medicine in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the medical practice in reliance on this authorization.
- I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.
- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the federal privacy regulations.

Description of information to be used or disclosed:
(Please check all that apply)

____ Medical ____ Financial ____ Appointments ____ Scripts ____All Information

____ I do not wish to assign a patient representative at this time.

NAME	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____
4._____	_____

This authorization does not have an expiration date. I can revoke or change this information at any time in writing to Deseret Family Medicine.
It is my responsibility to keep this information up to date.

Signature of patient_____ Date_____
(Parent or Guardian if patient is a minor)
____I am an emancipated minor.

Please use the following as means of communicating with me:
(Please check as many as you would like)

____ Home Phone_____ Leave Message: Yes _____ No_____

____Cell Phone_____ Yes_____ No_____

____Work Phone_____ Yes_____ No_____

____Fax_____

This information does not have an expiration date. I can change this information at any time in writing to Deseret Family Medicine. It is my responsibility to keep this information up to date.

Signature of patient_____ Date_____
(Parent or Guardian if patient is a minor)
____I am an emancipated minor.

3/2012