Kathryn Naus MD PA

7.30 Patient Authorization for Personal Representative
Please print all information, then sign and date form at bottom.
Type of Authorization: Personal Representative
Patient's name (Please print): ______________________ **Date of Birth:** ______________________

Purpose of request: I authorize **Kathryn Naus MD PA** to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my PHI. They may also consent or authorize the use or disclosure of my PHI:

____
Name of Personal Representative and Relationship (i.e. Spouse, family member, etc)

____
Address

____
City, State, Zip

____
Phone

Description of information to be disclosed – I authorize **Kathryn Naus MD PA** to disclose all of my PHI to my designated personal representative.

Circle one: Procedures Labs All Information

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.
Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

Kathryn Naus MD PA
1001 N. Waldrop Dr.
Suite 601
Arlington, TX 76012

Redisclosure – We have no control over the person (s) you have listed as your personal representative. Therefore, your PHI disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of **Kathryn Naus MD PA**.

7.34 Patient Authorization for Disclosure of Protected Health Information via telephone.
Type of Authorization: Telephone Contact
Patient's name (Please print): ______________________ **Date of Birth:** ______________________

Purpose of request – I authorize **Kathryn Naus MD PA** to disclose my PHI in the following manner:
(Check the box that applies)

☐ Home Telephone: ______________________ ☐ Cell or Work Telephone: ______________________

☐ Leave detailed messages on my answering machine/ voice mail

☐ Leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine/voice mail

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.
Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

Kathryn Naus MD PA
1001 N. Waldrop Dr.
Suite 601
Arlington, TX 76012

X ______________________ ______________________
Patients Signature Date