Isleta Health Center
1 Sagebrush St. • P.O. Box 580
Isleta, NM 87022
Phone: 505-869-3200

AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE

EFFECTIVE DATE: _____

Please sign this form to appoint a personal representative(s). Isleta Health Center will provide your appointed personal representative(s) the same rights to your Protected Health Information (PHI) that are provided to you.

PART A: Person Appointing a Personal Representative

_____ ____ _____
First Name MI Last Name

_____ (____) _____ (____) _____
Date of Birth Home Phone Cell Phone

_____ _____ _____
Address City / State Zip

PART B: Your Rights under Federal Law

You have the right to authorize that your PHI held by Isleta Health Center be released to and/or received by the person(s) you identify on this authorization form. Upon request, you are entitled to receive a copy of this signed form.

YOUR RIGHT TO REVOKE: You may revoke this authorization at any time by giving written notice to Isleta Health Center. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact Isleta Health Center for more information if you desire to cancel this authorization.

PART C: Authorization to Appoint a Personal Representative

1. Please state the purpose of this authorization:
   - ☐ To appoint a personal representative(s) to act on my behalf to make healthcare decisions under applicable state law. (45 CFR.164.502(g)(2)-(3))
   - ☐ Other, for the following purpose (please specify and describe in detail):

     _____
2. I hereby authorize the request and release of my PHI held by Isleta Health Center to my personal representative(s). By appointing the person(s) named on this form as my personal representative(s), I understand that I am authorizing Isleta Health Center to give this person(s) access to my PHI and medical records and the right to talk to Isleta Health Center about my health care.
3. I authorize the person(s) named on this authorization form act as my personal representative(s).
4. I understand that my authorization will remain in effect for the length of the time specified below:
   - ☐ Disclose my Personal Health Information up to one (1) year from the date of this form.
   - ☐ Beginning _____ for **indefinite period of time**.
   - ☐ Disclose my Personal Health Information for a specified period.

     Beginning _____ and ending _____(mm/dd/yyyy)

Authorization to Appoint a Personal Representative

5. My Personal Representative(s) Information:

A.

First Name **Middle** **Last Name**

My Representative's Relationship to Me **Date of Birth**

Address

City / State / Zip Code

( ) ( )

Home Phone **Alternative Phone**

B.

First Name **Middle** **Last Name**

My Representative's Relationship to Me **Date of Birth**

Address

City / State / Zip Code

( ) ( )

Home Phone **Alternative Phone**

C.

First Name **Middle** **Last Name**

My Representative's Relationship to Me **Date of Birth**

Address

City / State / Zip Code

( ) ( )

Home Phone **Alternative Phone**

I, _____ (Please print), having had full opportunity to read and consider the contents of this authorization, agree that the above named person(s) act as my Personal Health Care Representative. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, who is not subject to federal health information privacy laws.

Patient Signature: _____ **Date:** _____

IHC Staff Signature: _____ **Date:** _____

☐ Entered Into RPMS

☐ Scanned Into Vista

☐ Copy To Dental