Patient Representative Release Authorization

By filling out this form and signing below:

I give ConnectCare and Wellness permission to review my health history with my patient representative(s) (listed below). I understand this may include sensitive details, such as:

- Transmissible illness testing and/or treatment, including HIV/AIDS
- Drug and alcohol abuse
- Behavioral and mental health issues

This permission will only expire if I cancel or change it. I can cancel or change it at any time. Changes must be made in writing and sent to ConnectCare and Wellness at the address on this form. I understand that changes or cancellations:

- Will not affect informational ready shared with my representatives
- Will not begin until ConnectCare and Wellness receives my written request

If I want to change my representative(s),I must complete a new form. I understand that when I fill out a new form, my old form is no longer valid. My representative(s) can't share information without my permission. If they share without my permission, federal law may not protect those actions.

I agree to let ConnectCare and Wellness talk to my representative(s).I do not need to sign this form to make sure I get treatment.

My information (patient)

Name:_____ Date of Birth:____

_____Street:_____ City:_____

My Patient Representative(s)'s Information: Please list your patient representative(s).Staff will ask your patient representative(s) for your name and birth date. Please be sure they have this information.

1. Representative's Name:_____Relationship to Patient:_____ Telephone #:_____
2. Representative's Name:_____Relationship to Patient: _____Telephone #:
3. Representative's Name:_____Relationship to Patient: _____Telephone #:

_____ _____

Signature of Patient or Legal Representative Date

_____

If signed by Legal Representative, relationship to patient