

## Patient Representative Release Authorization

By completing this form I authorize Fallon Clinic to discuss my protected health information with one or more representatives identified. I may add or delete up to three individuals at any time by completing this authorization. This authorization includes but is not limited to the discussion of sensitive information such as HIV testing, venereal disease, alcoholism/alcohol tests, drug dependency, addiction or abuse, illegitimacy of birth, mental illness or retardation, communications to social workers, psychotherapists, psychologists, family or marriage counselors or other mental health advisors that could be sensitive to the patient. By signing here I give permission to Fallon Clinic to discuss protected health information without restrictions to the below named party(s).

**This form does not allow access to medical records through Epic.**

### 1. Patient Information

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Day/Work Telephone #: \_\_\_\_\_

**2. Patient Representative(s):** Please identify up to three individuals to be your Patient Representative. Please ensure that the designated individual(s) below will need to provide the following information on you prior to Fallon Clinic discussing personal health information on your behalf:

- Patient Name
- Patient Date of Birth

And one of the following:

- Patient Address
- Patient Fallon Clinic Medical Record Number

Please check one of the following boxes:  Add  Delete

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Patient Representative Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Please check one of the following boxes:  Add  Delete

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Patient Representative Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

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Please check one of the following boxes:  Add  Delete

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Patient Representative Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

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## 2. Authorization

I authorize Fallon Clinic to discuss my medical care without restrictions with the individual(s) identified above. I understand that there is no expiration date, and I may add or delete up to three individuals at any time by completing a new authorization. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department (HIM). I understand that the revocation will not apply to information that has already been provided in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Fallon Clinic HIM Department at (508) 721-1142.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness

### Mail Completed Form to:

Fallon Clinic  
Medical Records Department  
35 Millbury Street  
Auburn, MA 01501