Patient Authorization for Personal Representative
Southpointe Pediatrics

Patient Name: _______________________________________

Date of birth: _____________________

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information.

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Name of Personal Representative **Phone #**

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Address

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City, State, Zip

- **Description of information to be disclosed**: I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization**: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practice, 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: Southpointe Pediatrics
  8851 Southpointe Dr C-1
  Indpls., IN 46227
  Attn: Privacy Manager

Redisclosure: We have no control over the person (s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

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Patient Signature (Must be 18 years old to sign this) **Date**

Copies of signed authorizations are available upon request.