Maimonides
Midwood Community Hospital

HIPAA Personal Representative Form

Patient Information – Please Print

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip Code: _____

Telephone # most easily reached: _____

I hereby authorize the individual named below to act as my personal representative with respect to my Protected Health Information (PHI). This includes the authority to access, receive, and discuss my medical records and health information. I am also aware that I may limit access to my records if I specify below.

HIPAA Representative Information - Please Print

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip Code: _____

Telephone # most easily reached: _____

Relationship to Patient: _____

I grant to the HIPAA Representative named above access to:

☐**Full access to all medical records and health information** – note separate box below is also required for HIV, psychiatric and substance abuse access.

☐**Other** - Specify limits or specific health care incident: _____

By checking the appropriate categories and by signing below, I (patient) am granting my HIPAA Representative access to additional health information.
I understand that the information in my medical record may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representative access to information relating to:
(**<u>you must initial each area</u>** you wish the HIPAA Representative to have access to)
_____ Alcohol, drug, or substance abuse information
_____ AIDS, HIV-related information (including AIDS related testing and results)
_____ Mental Health
_____ Sexually Transmitted Disease information
_____ Genetic information
_____ Research Information

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The confidentiality of this record is required under New York State and Federal Law. This material shall not be transmitted to anyone without written consent or authorization.

Signature of Patient for this box: _____ Date: _____

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1. I understand that I may revoke this HIPAA Representative designation at any time by notifying the Health Information Management Department at the following address: **2525 Kings Highway, Suite 1F, Brooklyn NY 11229**
Attention: Health Information Management Department, in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Maimonides Midwood Community Hospital prior to their receipt of the revocation.

2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.

4. I understand that this Authorization will remain in effect until: (Must check one)
☐ Revoked in writing by the patient

☐ On the following date: _____

Signature of Patient: _____Date: _____

Signature of HIPAA Representative: _____Date: _____

(Form will not be valid unless all appropriate blanks are filled)

*YOU MAY REFUSE TO SIGN THIS FORM