DFD Russell Medical Center
(the Health Care Provider)

APPOINTMENT of AUTHORIZED REPRESENTATIVE

Note: This form is used to confirm a Patient's/Individual's permission that the Health Care Provider may discuss or disclose the Individual's PHI to a particular person who acts as their Authorized Representative. Use of their information is strictly limited to that purpose described above.

Section A: Individual's Information

By signing this form in Section E below, I understand and agree that the Health Care Provider may disclose my personal health information (PHI) as defined in Section B below to my Authorized Representative(s) named in Section C below.

Name: _____ Date of Birth _____

Address: _____

Telephone Numbers: _____

Please Note: This does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative or if you want to set up a living will, please discuss this with your primary care provider or your attorney.

Section B: Type of Information

- All Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information.

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:

I understand that your general policy is not to disclose my PHI to other persons, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss my PHI with, and to disclose my PHI to, the person(s) named below for any purpose, including payment for services. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my PHI may no longer be protected by those privacy laws and my authorized representative might further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

Authorized Representative #2:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

I understand that I have the right to limit the information that you disclose under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure (if any):

_____

_____

Section D: Expiration and Revocation

This authorization to disclose PHI to my Authorized Representative will continue for up to 30 months from the date of this Appointment. I understand that I have the right to revoke or terminate this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization **in writing** by providing written notice of my decision to the Contact Person listed below.

ATTN: Privacy Officer
DFD Russell Medical Center
180 Church Hill Road
Leeds, ME 04263

I understand that my revocation of this authorization will not affect any action that you have already taken in reliance on this Appointment, nor will it affect any information that you have already disclosed based upon this authorization before you actually receive my written request to revoke the Appointment.

Section E: Signature / Authorization

I have had full opportunity to read and consider the contents of this Appointment of Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that the Health Care Provider to use and/or disclose my PHI information to the person(s) named in Section C for the purpose described above.

Signed: _____ Date: _____

Print Name: _____