Yale Medicine | Yale NewHaven Health

Designation of Patient Spokesperson

Yale New Haven Health (YNHHS) and Yale Medicine (YM) allow patients to designate a patient spokesperson. A patient spokesperson is an adult family member or friend who is authorized by the patient to discuss their medical information with the patient's healthcare team for the purposes of coordination of care or payment for care. For example, a patient may want their spouse or adult child to assist in billing questions, to book appointments on their behalf or to be apprised of their health status. Completing and signing the Designation of Patient Spokesperson form does not give the spokesperson authority to make healthcare decisions for the patient.

I understand that by voluntarily signing this form I am identifying, authorizing, and granting permission to the family member or friend below to discuss my medical information with my healthcare team. I am also aware that I may limit sharing of my information with my patient spokesperson as noted below.

Patient Name (First, MI, Last Name):	
Patient Address	
Date of Birth (MM/DD/YYYY):	**Phone Number:**
Spokesperson Name (First, MI, Last Name):	
Spokesperson Relationship to Patient:	**Spokesperson Phone Number:**

I authorize the Spokesperson named above to receive medical information about me for purposes of assisting me with my healthcare:

☐ All of my medical information

☐ Other, please specify any limitations or designate a specific encounter: _____

_____

Information disclosed may include HIV, mental health, sexually transmitted disease and/or substance use treatment information. Please initial next to the information which you **DO NOT** want disclosed to your patient spokesperson:

____ HIV/AIDS ____ Substance Use (Alcohol/Drug Use) ____ Mental Health ____ Sexually Transmitted Disease

1. I understand that I may revoke a spokesperson designation at any time by contacting PatientIdentity@ynhh.org; however, if I do revoke the authorization, it will not have any effect on any actions taken by YNHH and/or YM prior to their receipt of the revocation.
2. I understand that this authorization is voluntary and that I may refuse to sign this authorization.
3. I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether or not I sign this authorization.
4. I understand that information disclosed in response to this authorization may be subject to re-disclosure by recipient and will no longer be protected under the terms of this authorization or by federal privacy regulations.
5. I understand that this authorization will remain in effect unless otherwise revoked by me.

SIGNATURE:

_____ _____

Signature of Patient or Authorized Representative** **Date**

If not patient, please indicate relationship: _____

***Must provide proof of legal authority (except parent of a minor)*

Interpretation Services (if necessary): An interpreter facilitated the communication between the health care provider(s) and the patient or authorized patient representative in _____ (language) to assist in obtaining informed consent or sharing/acknowledging information.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: _____ AM/PM Date: _____

Check here if: ☐ Telephone ☐ Video ☐ In person ☐ Bilingual Competency Program Approved Staff

ID Number (telephone/video only): _____

_____ Print Name of Interpreter

_____ Signature of **Interpreter (in-person only)**

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Available in Spanish