

Designation of Patient Spokesperson

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information - Please Print

Form with fields for Patient Name, Date of Birth, Address, and Phone Number.

Authorized Individual - Please Print

Form with fields for Name, Address, Phone Number, and Relationship to Patient.

I grant to the individual named above access to:

- ___ All of my PHI - note separate box below is also required for HIV, psychiatric and substance abuse access.
___ Other - Specify limits or specific health care incident

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that if I sign this box, I am specifically authorizing my HIPAA Representative access to information relating to: Substance Abuse, Mental Health, Psychotherapy Notes, HIV related information.

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient for this box: _____ Date: _____

- 1. I understand that I may revoke these designations at any time by notifying the appropriate Yale University Department/Physician in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Yale University 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: (Must check one)
() expire 1 year from the date executed: or
() be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient/Personal Representative: _____ Date: _____

Name of Personal Representative: _____ Relationship to Patient _____

YOU MAY REFUSE TO SIGN THIS FORM