Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center • Harvest Family Health Center • Wilson Community Health Center

PERSONAL REPRESENTATIVE

Patient Information (Please print clearly):

Patient Name: _____
Last *First* *Middle*

Date of Birth: _____/_____/_____ Medical Record Number_____
MO DAY YR

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail address: _____

Provide the names of the patient's legal guardians if the patient is a minor.

Name	Relationship to the Child	Contact Number	Email

Authorized Use and/or Disclosure:
This authorization does not provide the Personal Representative with any authority, either implied or direct, over any treatment or direct care decisions, except for the treatment of minors as indicated below.

I understand that CFHC, Inc. does not disclose my or my child's protected health information to other parties, except those directly involved in my or my child's care, without my written authorization. For this reason, I authorize you to discuss and disclose my or my child's protected health information to the person(s) named below to assist with, or facilitate, the coordination of my or my child's care. I also understand that if my or my child's Personal Representative is not a healthcare provider or an entity subject to federal or applicable state privacy laws, my or my child's protected health information may no longer be protected by those privacy laws, and my or my child's Personal Representative may further disclose my or my child's protected health information without my authorization. I acknowledge that my authorization is voluntary.

Personal Representatives

Name	Date of Birth	Phone Number	Relationship to the Patient	Address of Representative

For Parents/Guardians:
The above Authorized Representative(s) have my permission to bring in my child for medical/dental care without my presence. He/she will act as my child's personal representative, serve as his/her chaperone, and is able to consent to my child's care. I am aware that the adult presenting with the child is responsible for payment of the patient's portion at the time of service.

_____(initial) My child is 16 years or older, and I give my child permission to receive care without my presence. He/she may consent to treatment, make decisions regarding his/her medical care, and serve as his/her own chaperone. I am aware that my child is responsible for payment of the patient's portion at the time of service.

Limitations on Disclosure:
I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my or my child's Personal 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 to disclosure.

Describe Limitations: _____

_____

Revocation:
I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named above to remain my or my child's Personal Representative, I must revoke this authorization in writing. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you received my request to revoke it.

Send revocation to: Carolina Family Health Centers, Inc.
Privacy Officer
303 Green St. East
Wilson, NC 27893

Signature/Authorization:
I understand that, by signing this form, I am confirming my authorization that Carolina Family Health Centers, Inc. and its staff may use/disclose my or my child's protected health information to the person(s) named above for the purpose described.

_____
Patient/Parent/Legal Guardian's Name (printed)

_____ _____
Patient/Parent/Legal Guardian's Signature *Date*
(Parent must sign for minor child)

This form must be completed in person by the patient or the child's parent/legal guardian.