HIPAA PMA PHI DESIGNATION AUTHORIZATION

pediatric & medical associates, pc

Physicians
Ronald Angoff, MD
Nancy Brown, MD
Christine Patterson, MD
Gregory Germain, MD
Dyan Griffin, MD
Richard Uluski, MD

Nurse Practitioner
Meridith Cowperthwait, APRN
Jane Lawrence-Riddell, APRN

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New Haven, CT 06511
(203) 865-3737
FAX (203) 624-0751

325 South Main St.
Cheshire, CT 06410
(203) 271-1541
FAX (203) 272-3728

Date: ______________________________

Patient/Client Name: ______________________________

I, ______________________________, acknowledge the following individuals listed below,
(Legal Guardian or Patient Name if self)

as designated alternate representative(s) with respect to private health information (PHI). The scope of authorization granted by me for each designated alternate representative is clearly indicated below. I hereby authorize Pediatric and Medical Associates, P.C. to release relevant PHI related to the patient listed above, within the scope of that authorization, to those I have listed below as designated alternate representative(s). I understand that this authorization is valid unless and until it is modified or revoked, in writing, and properly presented to the records office of Pediatric and Medical Associates, P.C.

Signature:______________________________

Designated Alternate PHI Representative(s)

1. Name: ______________________________

   Relationship to Patient: ______________________________

   Scope of PHI Authorization: Full With Restrictions

   Restrictions: ______________________________

2. Name: ______________________________

   Relationship to Patient: ______________________________

   Scope of PHI Authorization: Full With Restrictions

   Restrictions: ______________________________

3. Name: ______________________________

   Relationship to Patient: ______________________________

   Scope of PHI Authorization: Full With Restrictions

   Restrictions: ______________________________

(PHIAUTH 2015/04)