UTAH VALLEY
OBSTETRICS & GYNECOLOGY

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Patient Name _____ Date of Birth_____

Purpose
This form allows you (the "Patient") to give Utah Valley OB/GYN providers permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information including diagnoses, procedures, billing data, and treatment plans.

Each patient who wishes to name a personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, please indicate below. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to anyone else who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, child, friend, and you must provide the information below for each person before we can treat that person as your Personal Representative. If you need additional forms, we will be happy to copy this form for you.

Please Note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions.

Authorized Use and/or Disclosure
I understand that Utah Valley OB/GYN's privacy practice is to not disclose my personal health information except for the purpose of treatment, payment, and health care operations, or as required by law without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named below for the purpose of assisting with or facilitating my health care and payment of any health benefits. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. Any such limitations must be described in Restrictions in this section.

Personal Representative 1 *(Please print clearly)*

Full Name_____ Phone Number_____
Relationship to You_____ Restrictions _____

Personal Representative 2 *(Please print clearly)*

Full Name_____ Phone Number_____
Relationship to You_____ Restrictions _____

This authorization to release information to my Personal Representative will automatically expire in three (3) years after the date of my last visit to Utah Valley OB/GYN.

I understand that I have the right to revoke or end this authorization at any time and may do so by giving written notice of my decision to the Privacy Official at the office of Utah Valley OB/GYN. I understand that my revocation of this authorization will not affect any action that has been taken or information that has already been released, based upon this authorization, before receiving my request to revoke authorization.

I have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that Utah Valley OB/GYN may disclose my protected health information to the person (s) named on this form, for the purpose described above.

Routine Results Contact / Confirming Appointments
Permission is given for Utah Valley OB/GYN to leave routine exam results & confirm office visits:
(check all that apply & preferred number)

- o Home answering machine: _____
- o Cell phone: _____
- o Email: _____

Signature_____ Date _____