HealthSource of Ohio

Personal Representative
Authorization / Revocation to Share Health Information

Patient's Legal Name: _____ Date of Birth: _____ MRN: _____

I understand that federal law prevents the release of my private healthcare information without my consent under most circumstances. This can prevent my provider from discussing my health with family and others that ***I DO*** want informed or to assist in my medical care.

Authorization:

I hereby give permission for my doctor/clinician/dentist or their staff to discuss my healthcare with the following person(s) for a period of 12 months:

Name:	**Relationship:**
1. _____	_____
2. _____	_____
3. _____	_____

_____ _____

Signature of patient, parent, or guardian
(or electronic signature via Electronic Medical Record)

Date Signed

Revocation:

I hereby permanently take back permission for my doctor/clinician/dentist or their staff to discuss my healthcare with *(List below all members and their relationship to you):*

Name:	**Relationship:**
1. _____	_____
2. _____	_____
3. _____	_____

_____ _____

Signature of patient, parent, or guardian
(or electronic signature via Electronic Medical Record)

Date Signed