



AUTHORIZED REPRESENTATIVE FORM

Phone: 509-773-4022

Fax: 509-773-4543

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the Authorized Representative named below to have authority to access my protected health information (PHI) to assist in my care.

Patient Information –Please Print

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip Code: _____

Phone Number: _____ MRN (if applicable): _____

Authorized Representative Information—Please Print

Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip Code: _____

Phone Number: _____ Relationship to Patient: _____

***The following items must be initialed as they will be included in the disclosure of other medical information when present:**

- _____ *AIDS/HIV and other Communicable Diseases
- _____ *Behavioral Health Care/Psychiatric Care/Mental Health Information
- _____ *Alcohol and/or Drug Abuse
- _____ *Genetic Testing Information

1. I understand that I may revoke this Authorized Representative designation at any time by notifying the appropriate Klickitat Valley Health department in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Klickitat Valley Health prior to the 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 be effective for the lifetime of the patient unless revoked (see #1 above).

Signature of Patient: _____ Date: _____