Yale Health Center
55 Lock St
PO Box 208237
New Haven, CT 06520-8237
Phone (203) 432-7741
Fax (203) 436-5536

Designation of a Personal Representative and Authorization to Access Protected Health Information

This authorization grants permission to the personal representative named below to have access to my protected health information. I hereby authorize Yale Health clinicians, care team or clinician name _____to use and disclose my protected health information**.** I understand that this authorization is voluntary. I understand that once this information is released to the personal representative named below, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ DOB _____

Address: _____Phone: _____

Personal representative _____Relationship to patient: _____

Address: _____ Phone: _____

The information will be used or disclosed for the following purposes:
( ) At my request ( ) Other: _____

Please read the three statements below carefully before signing this document:

1. I understand that I may revoke this authorization at any time by notifying the Yale Health HIPAA Privacy Office PO Box 208237, New Haven, CT 06520-8237 in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by ***Yale Health clinicians or care team*** prior to their 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 this authorization will: (***Must check one***)
   ( ) expire 1 year from the date executed; or
   ( ) be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient_____ Date _____

Witness _____ Date_____

I understand that this health information may include HIV-related information and /or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:
( ) Substance Abuse (including alcohol/drug abuse
( ) Mental Health
( ) Psychotherapy Notes
( ) HIV related information (including AIDS and related testing)
The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization provided in these statutes.

Signature of Patient _____ Date _____

Signature of personal representative _____ Date _____

(*Form will not be valid unless all appropriate blanks are filled)*

Printed name of personal representative: _____

Relationship to patient: _____

Witness_____Date_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

For Department Use Only:

Date received: _____ By: _____
Net ID