Yale HEALTH

Designation of Patient Spokesperson

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information – Please Print

Patient Name: _____ Date of Birth: _____Phone Number: _____

Address: _____

Authorized Individual - **Please Print**

Name: _____

Address: _____

Phone Number:_____ Relationship to Patient: _____

I grant to the individual named above access to:

___All of my PHI – *note separate box below is also required for HIV, psychiatric and substance abuse access.*

___Other - Specify limits or specific health care incident_____

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 if I sign this box, I am specifically authorizing my HIPAA Representative access to information relating to:

__ Substance Abuse (including alcohol/drug abuse)
__ Mental Health
__ Psychotherapy Notes
__ HIV related information (including AIDS 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 as provided in these statutes.

Signature of patient for this box: _____ Date: _____

1. I understand that I may revoke these designations at any time by notifying the appropriate Yale University Department/Physician in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Yale University 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 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: (***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/ Personal Representative: _____ **Date:** _____

Name of Patient Spokesperson: _____ **Relationship to Patient**_____

Signature of Patient Spokesperson: _____ **Date:** _____

YOU MAY REFUSE TO SIGN THIS FORM

Please mail, fax, or scan completed forms to: Yale Health, P.O. Box 208237, New Haven, CT 06520- 8237 or fax to 203-436-5536 or email to mailto:yhmedicalrecords@yale.edu.