**310 S. Roosevelt Goldendale, WA 98620 509-773-4022**

# AUTHORIZED REPRESENTATIVE FORM

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: __________________________________ Town, State, Zip Code: _________________

Phone Number: _____________________ MRN (if applicable): ___________________

**Authorized Representative Information –Please Print**

Name: ___________________________________ Date of Birth: _________________________

Street Address: __________________________________ Town, 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 <u>in writing</u>; 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: ______________**