



**OHIO
PEDIATRICS
INC**

Patient Authorization for Personal Representative

Please print all information then sign and date form at bottom.

Patient Name(s): _____

Purpose of Request: I authorize the practice to disclose and/or provide the protected health information of the above mentioned children to my personal representative for the purposes of receiving all protected health information. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my child/children's health information. He/she may also consent to authorize the use or disclosure of my child/children's health information.

Name of Personal Representative	Home Phone	Cell Phone

Address _____		

City, State, Zip _____		

(√) _____ Please designate this person as my Emergency Contact

- **Description of information to be disclosed:** I authorize the practice to disclose all of my child/children's protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative, or other individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request. This can be done in person or by mailing a request to: Ohio Pediatrics, Inc. • 1775 Delco Park Drive • Kettering, OH 45420.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Signature of Parent/Patient or Legal Representative _____
Date