Personal Representative Request

The purpose of implementing a Personal Representative Request is to enable another individual to act on your behalf with respect to:

- Making decisions about your health care,
- Requesting and /or disclosing your private health information, and
- Exercising all of the rights you have as a Community Health Service Inc. (CHSI) patient

A Personal Representative may either be legally appointed or designated by a Patient to act on his or her behalf.

- When a Personal Representative has been legally appointed, the Personal Representative should complete and sign this form. Supporting legal documentation, such as a power-of-attorney or with a court appointment that indicates full health care decision-making authority or guardianship papers, must be submitted with this form.
- When a Personal Representative is being designated by a Patient, the Patient needs to sign this form.

Note: *if your request is granted, it will affect only written and oral communications from Community Health Service Inc. (CHSI). If you also wish your employer, group health plan, physician or anyone outside of CHSI to make this change, you must obtain their agreement separately*.

Patient's Name: _____

Patient's Date of Birth:_____ **Patient ID number and/or MRN:**_____

Information to be released:

□ **Lab Report**	□ **Progress Note**	□ **Mental Health**
□ **X ray Report**	□ **Immunization Record**	□ **Other:**_____
□ **Billing Statement**	□ **Entire Record**	

Information of Personal Representative: *Only one person can be named below.*

Name of Personal Representative: _____

D.O.B of Personal Representative: _____ Relationship to Patient: _____

Address where communications should be sent, if different from patient address:

_____

Mailing Address *City* *State* *Zip Code*

What is the reason for this request? _____

_____

Verification Questions for personal representative

(In this section "You" and "Your" refer to the Personal Representative.)

The answers you provide below will be used to verify your identify if you call for private health information about the patient. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

PIN *(you may use any four digit number)* __ __ __ __

- Please **DO NOT** provide anyone else with the PIN
- You should keep a copy of this form for reference.

Please NOTE

- If the information on this form is not complete, CHSI will return the form to you, and this request will not be considered until CHSI receives complete information.
- Any previous request to send information to an alternate address will be disregarded. All future correspondence will be sent to the address specified on the previous page.
- You may change or revoke this request by sending a written request to CHSI, HIPAA Coordinator and 810 4th Avenue South, Suite 101, Moorhead, Minnesota 56560. You can also obtain a Change/Revoke form by calling CHSI.

Signature – Please complete either Section A or Section B.

A. Personal Representatives who are legally appointed:

I have read and understand the above information. I acknowledge that by signing this form I have the legal authority to act on behalf of the Patient.

To safeguard privacy and help make sure no one other than the person whom the patient designates receives Private Health Information, this request must be submitted with appropriate supporting legal documentation.

Signature of Patient/Parent/Guardian:_____ Date: _____
(This Line is for the Patient to sign, authorizing the Personal Representative.)

B. Personal Representatives designated by Patient:

To safeguard privacy and help make sure no one other than the person whom the Patient designates receives Private Health Information, this request must be signed by the Patient.

I have read and understand the above information. I acknowledge that by signing this form I authorize CHSI to treat my Personal Representative as myself. This request will be in effect until revoked in writing by me.

Signature of Personal Representative:_____ Date:_____

Witness - Please complete by signing

Staff Name (Print):_____ Title:_____

Staff Signature: _____ Date:_____

******If request is made by a Parent/Guardian for a minor child, complete the following******

Patient is a minor _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Site:_____