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Patient Authorization for Personal Representative
Please print all information, then sign and date form at bottom

Patient Name: _____

Date of Birth: _____ **EPA Record Number:** _____

Purpose of request: I authorize **Eye Physicians of Austin** to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

(A Personal Representative does **NOT** have the authority to make healthcare decisions on your behalf.)

Name of Personal Representative: _____ **Last 4 of SSN:**

Phone#: _____ **Address:**

City: _____ **State:** _____ **Zip:**

Description of information to be disclosed: I authorize **Eye Physicians of Austin** to disclose all of my protected health information to my designated personal representative.

Expiration or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another 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 to our Privacy Manager. This can be done in-person or by mailing a request to: **Eye Physicians of Austin, Attn: Privacy Manager, 5011 Burnet Rd, Austin, TX 78756.**

Disclosure: 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.

Patient Signature

Date