Mount Sinai UNITE HERE HEALTH

Patient Representative Authorization/Proxy Form

This form allows you to choose a patient representative (a designated person authorized by you) that allows MSHP-UHHHC to disclose/share your medical Information. *(Example: Spouse, Parent, Family member, or any person of your choice*) You may place limitations on the type of information that is to be disclosed, or choose not to select a representative.

PATIENT NAME: _____

PATIENT DOB: _____

Please check one: ❑I DO NOT wish to select a patient representative at this time.

❑I DO wish to select a patient representative at this time.(fill out below)

I _____ designate _____ as my representative(State relationship to patient). My signature below acknowledges that I give my authorization for MSHP-UHHHC to disclose any and all medical information pertaining to my care to the above named representative.

***Please indicate any restrictions/limitations of medical information to be shared with your representative:**

_____

_____

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_____

My designated representative can be reached:

Phone (Home) _____ Work _____

__**I have reviewed and I understand this form.**

__**I understand that I can withdraw my consent in writing at any time.**

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