UNICARE COMMUNITY HEALTH CENTER

HIPAA – REPRESENTATIVE AUTHORIZATION

PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ PHONE NUMBER _____

☐ I do not appoint any representative to act on my behalf at Unicare Community Health Center.

☐ I appoint _____ as my authorized representative, to act on my behalf for Unicare Community Health Center (UCHC) services described below.

AUTHORIZED REPRESENTATIVE

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO MEMBER _____ PHONE NUMBER _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

AUTHORIZED PERMISSIONS

- ☐ Make decisions about my treatment plan
- ☐ Update my demographic information
- ☐ Request medication refills
- ☐ Other: _____
- ☐ Change my Primary Care Provider
- ☐ Obtain Referral information
- ☐ Obtain diagnosis information

PATIENT RIGHTS AND ACCEPTANCE

I agree to have the authorized representative noted above, to act on my behalf for UCHC services outlined above. I understand that I do not have to sign this representative authorization and it is completely voluntary . I further understand that if the information provided by this authorization is disclosed (given) to another person, it may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving the health information by this authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. This authorization is effective immediately and will remain in effect for **one year from the date of signature**, or as indicated here: _____ (ending date). By signing below, I hereby authorize this designation.

PATIENT SIGNATURE _____ DATE _____

AUTHORIZED REPRESENTATIVE RIGHTS AND ACCEPTANCE

I understand that the I may revoke this authorization at any time, and I have limited power to act on the patient's behalf except for the permissions detailed in the "Authorized Permissions" section on this form. I understand that I may not transfer or reassign my designation.

By signing below, I hereby accept this designation.

AUTHORIZED REPRESENTATIVE SIGNATURE _____ DATE _____