CORNERSTONE
MEDICAL ASSOCIATES, LLC

Authorization for Disclosure of Protected Health Information (PHI) to Personal Representative(s)

Patient Name: _____ **Date of Birth:** _____

I authorize disclosures (information given out) of my Protected Health Information (PHI) to my personal representative(s) named below:

(Please check all that apply ✓)	**(Please name)**
❑ Legal Guardian	_____
❑ Spouse	_____
❑ Adult Child (Children)	_____
❑ Parent(s)	_____
❑ Attorney	_____
❑ Adult Next of Kin	_____
❑ Adult Friend	_____
❑ Court Appointed Representative	_____

NOTE: Under federal regulation, the physician may exercise his/her professional judgment to determine the scope and duration of a patient's objection or agreement to disclosures of information to the personal representative(s).

This agreement remains in force until rescinded, in writing, by the above named patient.

_____ _____
Patient's Signature or Representative's Signature Date

_____ _____
Witness Date