

# ALLIANCE MEDICAL GROUP

## HIPPA – INDIVIDUAL PRIVACY RIGHTS

### Request to Appoint an Authorized Representative

I understand your general policy is not to disclose my PHI to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my PHI to the individual(s) named below. I acknowledge that my authorization is voluntary. I understand I have the right to revoke this authorization, **in writing**, at any time. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization prior to written notification of the revoked authorization.

#### Authorized Representative #1

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_

#### Authorized Representative #2

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_

#### Confirmation of Authorization

I have had full opportunity to read and consider the content of this authorization form. I confirm this authorization is consistent with my request. I understand, by signing this form, I am confirming my authorization that Alliance Medical Group, Inc. may use and/or disclose my PHI to the person(s) named above for the purpose described above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth