PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Please print all information, then sign and date form at bottom.

Patient Name _____

Purpose of request- I authorize Donald J. Sabourin, DDS, PLLC to disclose or provide my protected health information to the following individuals who are authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative(s), they may exercise my right to inspect, copy and correct my protected health information:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Description of information to be disclosed- I authorize Donald J. Sabourin, DDS, PLLC to disclose all my protected health information to my designated personal representative(s) listed above.

Expirations or termination of authorization- This authorization will remain in effect until terminated by you, your personal representative(s) or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate- You have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure- We have no control over the person(s) you have lised as your personal representative(s). We have no control over how they may choose to share your protected health information. Therefore, your protected health information disclosed to them, under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

Patient Signature Date