PARRISH® MEDICAL CENTER

AUTHORIZATION FOR REPRESENTATIVE to Access Information via Internet

If you would like a family member, friend or other individual to assist you in monitoring your medical needs and would like this representative to have access to your medical information via HealthBridge Hospital Records, please complete the following information.

I _____ (insert name of patient), born on this date: _____, hereby authorize North Brevard County Hospital District/Parrish Medical Center (PMC) to use or disclose my protected health information and other personal information as described in this Authorization.

Persons/Organizations Authorized to Provide the Information: North Brevard County Hospital District/Parrish Medical Center (PMC)

Persons/Organizations Authorized to Receive the Information (Representative): _____

Representative's Email Address: _____ **Only one email per person.**

Representative's Primary Phone Number: _____

Personal Representative's Relationship to Patient: _____

Specific Purpose of the Disclosure: At the request of the patient.

This Authorization expires (Provide specific date or event. If not specified, authorization will automatically expire after one year from the date of signature): _____/_____/_____

Information to be disclosed: My entire medical record held by PMC as available through HealthBridge Hospital Records including, if applicable, information relating to particularly sensitive conditions such as substance abuse, mental health, HIV, and genetic conditions.

I understand that: (i) I may refuse to sign this Authorization and my refusal to sign will not affect how PMC treats me or my eligibility for health benefits; (ii) this Authorization is not for the use or disclosure of psychotherapy notes; (iii) I may revoke this Authorization at any time before the expiration date by notifying PMC in writing, but the revocation will not have any effect on any actions PMC took before it received the revocation; (iv) I may have a copy of this Authorization; and (v) any information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations, unless such redisclosure is expressly prohibited by other state or federal law.

Signatures:

Signature of Patient _____ Date _____

If patient is unable to sign, please fill in the information below:

Name of Individual or Personal Representative _____