

PATIENT REPRESENTATIVE IDENTIFICATION FORM

prevention diagnosis treatment surgery www.gispecialistsmemphis.com

Patient Name _____ Date _____

Chart Number _____

By law, the HIPAA Privacy Rule prohibits Gastrointestinal Specialists, P.C. from disclosing your **Protected Health Information (PHI)** to anyone without your authorization, except for treatment, payment, and health care operations. This rule became effective April 14, 2003.

Please list the names of all persons that you wish to have access to your Protected Health Information (PHI):

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Please list the name of the person(s) with whom we can discuss your bill:

Name _____ Relationship to Patient _____

If applicable, please list the name of your **Legal Representative**:

Name _____ Relationship to Patient _____

Please Check One: by what authority is this person your Legal Representative?

- Next of Kin
 Guardian
 General Power of Attorney
 Health Care Power of Attorney

In order for us to disclose your Protected Health Information, the above representatives must be able to provide two (2) of the three (3) identifiers listed below:

- Patient's social security number
- Patient's date of birth; or
- Patient's zip code

Patient or Patient Representative Signature

Date