Pediatric & Medical ASSOCIATES

Excellent care from head to toe

HIPAA PMA PHI DESIGNATION AUTHORIZATION

Date: _____

Patient/Client Name: _____

I, _____, acknowledge the following individuals listed below,
(Legal Guardian or Patient Name if self)

as designated alternate representative(s) with respect to private health information (PHI). The scope of authorization granted by me for each designated alternate representative is clearly indicated below. I hereby authorize Pediatric and Medical Associates, P.C. to release relevant PHI related to the patient listed above, within the scope of that authorization, to those I have listed below as designated alternate representative(s). I understand that this authorization is valid unless and until it is modified or revoked, in writing, and properly presented to the records office of Pediatric and Medical Associates, P.C.

Signature:_____

Designated Alternate PHI Representative(s)

1. Name: _____

   Relationship to Patient: _____

   Scope of PHI Authorization: Full With Restrictions

   Restrictions: _____

2. Name: _____

   Relationship to Patient: _____

   Scope of PHI Authorization: Full With Restrictions

   Restrictions: _____

3. Name: _____

   Relationship to Patient: _____

   Scope of PHI Authorization: Full With Restrictions

   Restrictions: _____

Physicians
Ronald Angoff, MD
Katelyn Cusmano, MD
Christine Patterson, MD
Gregory Germain, MD
Dyan Griffin, MD
Richard Uluski, MD

Nurse Practitioner
Meridith Cowperthwait, APRN
Jane Lawrence-Riddell, APRN, IBCLC
Lindey Quinn, APRN

_____

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