Outer Cape
HEALTH SERVICES

Patient Representative Release Authorization

By filling out this form and signing below:

I give Outer Cape Health permission to review my health history with my patient representative(s) (listed below). I understand this may include sensitive details, such as:

- Alcohol and/or Drug Abuse Treatment
- HIV/ Communicable Disease
- Genetic Testing
- Mental Health Services

I also give permission to my representative to request a copy of my medical record on my behalf with the understanding that my Patient Representative will complete an Authorization for Request of Protected Information Form.

This permission will only expire if I cancel or change it, or upon my death. I can cancel or change it at any time. Changes must be made in writing and sent to Outer Cape Health Services at the address on this form. I understand that changes or cancellations:

- Will not affect information already shared with my representatives
- Will not begin until Outer Cape Health Services receives my written request

If I want to change my representative(s), I must complete a new form. I understand that when I fill out a new form, my old form is no longer valid. My representative(s) can't share information without my permission. If they share without my permission, federal law may not protect those actions

I agree to let Outer Cape Health Services talk to my representative(s). I do not need to sign this form to make sure I get treatment.

My Information (Patient) Name: _____ Date of Birth: _____

Street: _____

City: _____ State: _____ Zip: _____

Patient Representative(s): Please list individuals to be your patient representative. Staff will ask for your name and date of birth before speaking with your representative. Please make sure they have this information.

1. Representative's Name _____ Relationship to Patient: _____
   Telephone #: _____
2. Representative's Name _____ Relationship to Patient: _____
   Telephone #: _____
3. Representative's Name _____ Relationship to Patient: _____
   Telephone #: _____

I understand by signing below I give permission to Outer Cape Health Services to talk to my representative(s) listed above about my health information without restrictions.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

Please send this form into the Medical Records Department or bring it into your clinic:
Outer Cape Health Services
PO BOX 598 Harwich Port, MA 02642
Fax #: (508) 487-6298