**Marbleton-Big Piney Clinic**
103 W. Third Street
Marbleton, WY 83113
307.276.3306

SUBLETTE COUNTY HEALTH

**Pinedale Medical Clinic**
625 E. Hennick Street
Pinedale, WY 82941
307.367.4133

# Personal Representative Authorization Form

By completing this form, you are granting Sublette County Hospital District (SCHD) permission to release your personal information to one or more personal representatives. Only the information indicated below will be released to your personal representative. This personal representative authorization is valid for **ONE YEAR ONLY** from the date of signature.

**Patient Information**

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

Medicare Beneficiary # (if applicable)

_____

**I request and authorize SCHD to release my personal health information to:**

Name: _____ Phone: _____

Address: _____ Relationship to Patient: _____

_____

**This request and authorization apply to:**

- ☐ Financial Information (Premium billing, claims, etc.)
- ☐ Health Care Information (Health/wellness information, appeals, claims diagnosis, etc.)
- ☐ Demographic Information (Address changes, etc.)
- ☐ Sensitive Health Information (HIV/AIDS status, etc.)
- ☐ Mental Health Records (Payment, diagnosis, etc.)
- ☐ I authorize my personal representative to act on my behalf in connection with any appeals for coverage.

I may withdraw my authorization at any time by submitting a written request to SCHD's privacy clerk. If I do, I understand that my personal health information may have already been released to my personal representative after I gave permission. I have carefully read and understand the above and do herein expressly and voluntarily authorize disclosure of the above information and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons listed above.

**Patient's Signature**: _____ **Date**: _____

**Personal Representative**: I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended or prohibited from practice before the Department of Health and Human Services; that I am not as a current or former employee of the United States, disqualified from acting as a Medicare beneficiary representative.

**Personal Representative Signature**: _____ **Date**: _____