Clarksville Internal Medicine, PLC

Identification of Personal Representative(s)

Name of Patient: _____

Date of Birth: _____

I hereby grant the individual named below access to my protected health information. This individual may receive and act upon information received from Clarksville Internal Medicine PLC. This information may include clinical information about my care, as well as billing information related to my insurance coverage and payment activity for services rendered by Clarksville Internal Medicine PLC. I also authorize individual listed below to pick up prescriptions, medical information, labs results and billing information on by behalf.

- I understand I may revoke the authorization at any time.
- I understand that I have the right to review the information being disclosed to my personal representative.
- I understand that the protected health information released to my personal representative may be further disclosed by the recipient. Clarksville Internal Medicine PLC cannot guarantee the further safeguarding of the health information after disclosure.

Personal Representative	Date of Birth	Relationship	Phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ I hereby grant my personal representative to have access to my protected health information at Clarksville Internal Medicine, PLC

☐ I do not wish to identify a personal representative at this time.

_____ _____

Patient Signature Date Signed