Kewa Pueblo Health Corporation

P.O. BOX 340 85 W. HIGWAY 22
SANTO DOMINGO PUEBLO, NEW MEXICO 87052
TELEPHONE (505) 465-3060 FAX (505) 465-1178

AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE

By signing this form to appoint a personal representative(s), Santo Domingo Health Center (SDHC) will provide your appointed personal representative(s) the same rights to your Protected Health Information (PHI) that are provided to you.

Patient Appointing a Personal Representative Medical Record #: _____

First Name _____ Middle _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone number _____

Your Rights under Federal Law: You have the right to authorize that your PHI held by Santo Domingo Health Center be released to and/or received by the person(s) you identify on this authorization form. Upon request, you are entitled to receive a copy of this signed form.

Your Right To Revoke: You may revoke this authorization at any time by giving written notice to Santo Domingo Health Center or completing a new Authorization to Appoint a Personal Representative Form authorizing a new Personal Representative. Please contact **Santo Domingo Health Clinic** at **(505) 465-3060** for more information if you desire to cancel or update a new authorization. Cancellation of this authorization will not affect any action we took prior to receiving your written notification.

My Personal Representative Information:

First Name _____ Middle _____ Last Name _____

Address _____

( ) Home Phone Number _____ ( ) Alternative Phone _____

My Representative's Relationship to the Patient _____ Date of Birth _____

Authorization to Appoint a Personal Representative

1. Please state the purpose of this authorization:
   - ☐ To appoint a personal representative(s) to act on my behalf to make healthcare decisions under applicable state law. (45 CFR.164.502(g)(2)-(3))
   - ☐ Other, for the following purpose (please specify and describe in detail):

   _____

2. I hereby authorize the request and release of my PHI held by Santo Domingo Health Center to my personal representative(s). By appointing the person(s) named on this form as my personal representative(s), I understand that I am authorizing Santo Domingo Health Center to give this person(s) access to my PHI and medical records and the right to talk to Santo Domingo Health Center about my health care.

3. I authorize the person(s) named on this authorization form to act as my personal representative(s).

4. I understand that my authorization will remain in effect for the length of the time specified below:
   - ☐ Disclose my Personal Health Information up to **one (1) year** from the date of this form.
   - ☐ Disclose my Personal Health Information for a specified period: (Less than a year)

     Beginning _____ and ending _____(mm/dd/yyyy)

I,_____, having had full opportunity to read and consider the contents of this
(Please print)
authorization, agree that the above-named person(s) act as my Personal Health Care Representative. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, who is not subject to federal health information privacy laws.

_____	_____	_____	_____
Patients/ Legal Guardian Signature	Patient Name (Print)	Date of Birth	Date
_____	_____	_____	
SDHC Staff/Witness Signature	Date	Medical Record #	

My Personal Representative ID

Yearly)