Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

Cheryl Lynn T. Rudy, M.D.
Cheryl L. Leialoha, M.D.
Eric C. Gertz, M.D.
Laura A. Spector, D.O.

Patient Representative Form

This form may be used to allow you to designate persons who are involved with your care and the limited extent that you permit Hawaii Women's Healthcare to allow your designated person to act on your behalf concerning your information.

Patient Name: ______________________________ Date of Birth: ________________

Other Names I May Be Known By: ____

Address: ____

City: __________________________ Zip code: ________________________

Home: _________________________ Cell: ___________________________

I understand that your general policy is NOT to disclose my/my daughter's protected health information (PHI) to others except those directly involved in my care, without my authorization or as permitted or required by law. For this reason, I authorize Hawaii Women's Healthcare LLC, to used and disclose my/my daughter's PHI to the person(s) named below for the purpose of assisting with or facilitating the coordination of my/my daughter's health care or payment for these services. I understand this declaration does not allow those designated to make health care decisions for me/my daughter.

	Names	Relationship	Contact Information
1			
2			
3			

<u>Scope of Authority:</u> The individuals I have listed above are given the authority to discuss with Hawaii Women's Healthcare or make updates or changes to the following (please initial all that apply):
Initials:____ Financial information such as billing, payment, updating my insurance information.

Initials:____ Health care information such as information regarding my condition and/or treatment, making/verifying/changing appointments.

Initials:____ Demographic information only such as address changes, etc.

Initials:____ I authorize the above named person to have full and direct access to my medical records.

Initials:____ Other (please specify)____

Initials:____ **Sensitive Information**: I understand my health information and financial records may contain sensitive information such as drug or alcohol abuse, mental health and HIV/AIDS status. My initials indicate that I specifically authorize Hawaii Women's Healthcare to share this information with those listed above to the extent that they are involved with my care.

Voluntary: This authorization is voluntary. You may refuse to sign this form. Hawaii Women's Healthcare will not condition your care or its services on receiving this authorization. You will receive a signed copy of this authorization.

Re-Disclosure: I understand that the information released to the person(s) named above may no longer be protected by federal privacy regulations.

Expiration: I understand that this authorization will expire (please check one):

☐ One (1) year from the date signed below

☐ Upon conclusion of the following___________________________ unless revoked earlier.

Right to Revoke: I understand that I may revoke this authorization at any time by notifying Hawaii Women's Healthcare in writing. I also understand that revoking this authorization will not apply to any information released by Hawaii Women's Healthcare before they received the written revocation.

My Responsibility: I understand it is my responsibility to update this information annually and as needed.

Signature: ____

Print Name: ________________________________ Date: _______________________

If signed by someone other than the patient, please describe your authority to act on behalf of the Patient: (e.g., parent, designated power of attorney) ________________________________
You may be asked to provide documentation.

For office use:

MR Number________________ Date Received:____________________