WMC Health | WMCHealth Physicians
Advanced Physician Services
Westchester Medical Center Health Network

Patient Representative Authorization Form

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

This form does not serve as an advanced directive such as a New York State Health Care Proxy Form or a Durable Power of Attorney

Patient Representative Information

I hereby give permission to WMC Health Advanced Physician Services, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information, and to discuss all payment issues with the individual designated below.

Name of Individual: _____

Relationship to Patient:_____

Date of Birth:_____ Telephone number:_____

Address:_____

Patient Signature:_____ Date:_____

Please note:

- A separate authorization must be completed to share highly sensitive information such as HIV, alcohol and substance abuse treatment, and/or mental health information.
- This does not grant the patient representative the right to access printed medical charts or information and does not give them right to request them on the patient's behalf.
- In order to revoke the rights of the Patient Representative listed above, a new form must be completed with updated information.