CHAPA-DE INDIAN HEALTH

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize Chapa-De Indian Health to speak to the following personal representative regarding (check one):

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

□ Only the following types of information:

_____
_____
_____
_____

The above medical information shall only be released to the following persons:

Name of Personal Representative	**Relationship**	**Phone #**
_____	_____	_____

I understand that I may terminate this Personal Representative Authorization form and I must notify Chapa-De in writing regarding termination and effective date.

This authorization shall remain valid (check one)

□ Until revoked in writing

□ Until Date of _____

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Account Number: _____