CANONCITO BAND OF NAVAJOS
HEALTH CENTER INC.
129 Medicine Horse Drive – To'Hajiilee, New Mexico 87026
Phone (505) 908-2307 / Fax (505) 908-2310

# AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE

Effective Date: _____

Please sign this form to appoint a personal representative(s). Canoncito Band of Navajos Health Center will provide your appointed personal representative(s) the same rights to your Protected Health Information (PHI) that are provided to you.

**PART A: Person Appointing a Personal Representative**

_____ _____ _____
First Name MI Last Name

_____ _____ _____
Date of Birth Home Phone Cell Phone

_____ _____ _____
Address City/State Zip

**PART B: Your Rights under Federal Law**

You have the right to authorize that your PHI held by Canoncito Band of Navajos Health Center, Inc. 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 Canoncito Band of Navajos Health Center, Inc. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact Canoncito Band of Navajos Health Center, Inc. for more information if you desire to cancel this authorization.

**PART C: 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. (45CFR.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 Canoncito Band of Navajos Health Center, Inc. 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 Canoncito band of Navajos Health Center, Inc. to give this person(s) access to my PHI and medical records and the right to talk to Canoncito Band of Navajos Health Center, Inc. about my health care.

3. I authorize the person(s) named on this authorization form 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)

PATIENT IDENTIFICATION

**Authorization to Appoint a Personal Representative**

5. My Personal Representative(s) Information:

**A.**

_____ _____ _____
First Name MI Last Name

_____ _____
My Representative's Relationship to Me Date of Birth

_____
Address

_____
City / State / Zip Code

_____ _____
Home Phone Alternative Phone

**B.**

_____ _____ _____
First Name MI Last Name

_____ _____
My Representative's Relationship to Me Date of Birth

_____
Address

_____
City / State / Zip Code

_____ _____
Home Phone Alternative Phone

**C.**

_____ _____ _____
First Name MI Last Name

_____ _____
My Representative's Relationship to Me Date of Birth

_____
Address

_____
City / State / Zip Code

_____ _____
Home Phone Alternative Phone

I, _____, having had full opportunity to read and consider the contents of this 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.

**Patient Signature: _____ Date: _____**

**CBNHC Staff Signature: _____ Date: _____**

PATIENT IDENTIFICATION