RELIANT MEDICAL GROUP
Part of OptumCare®

Patient Representative Release Authorization

By filling out this form I am giving permission to Reliant Medical Group to talk to the person(s) listed as my patient representative about my past, present, and future health information. I understand my health information may include general health information and sensitive information, for example, testing and/or treatment of communicable disease, HIV/AIDS, drug and alcohol abuse, and behavioral/mental health matters. I also understand that it is my responsibility to tell my representatives if they may share the information they receive with others. If they do share the information with others, those actions may not be protected under federal law.

I understand my permission given to Reliant Medical Group does not expire until I cancel or change it. Cancellation or changes to my permission may be made at any time and must be made in writing and sent to Reliant Medical Group at the address on this form. I understand that cancellation or changes will not apply to information already communicated to my representatives. I also understand that cancellation or changes will not begin until my written request is received by Reliant Medical Group. If I want to change my representatives, I must complete a new form. I understand that when I fill out a new form, my previous form is no longer valid.

I voluntarily give my permission to Reliant Medical Group to talk to my representative. I do not need to sign this form to assure treatment.

My Information (Patient)

Name:______________________________ Date of Birth:________________

Street:____

City:__________________________ State:__________ Zip:________________

Patient Representative(s): Please list individuals to be your patient representative. Staff will ask for your name and date of birth before speaking with your representative. Please make sure he/she has this information.

1. Representative's Name: ____
   Relationship to Patient: ______________________ Telephone #: (   ) _______ - ___________
2. Representative's Name: ____
   Relationship to Patient: ______________________ Telephone #: (   ) _______ - ___________
3. Representative's Name: ____
   Relationship to Patient: ______________________ Telephone #: (   ) _______ - ___________

I understand by signing below I give permission to Reliant Medical Group to talk to my representative(s) listed above about my health information without restrictions.

______________________________ ____________________
Signature of Patient or Legal Representative Date

____
If Signed by Legal Representative, Relationship to Patient

Please mail this form to the HIM department or call for questions about this form:

Reliant Medical Group HIM Department
385 Grove Street, Worcester, MA 01605
(508) 721-1142