DESIGNATION OF AUTHORIZED REPRESENTATIVE
WITH AUTHORIZATION TO RELEASE INFORMATION

Instructions: Fill out this form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

INDIVIDUAL DESIGNATING AUTHORIZED REPRESENTATIVE AND DISCLOSURE:

Client Name: _____ Date of Birth: _____

Address: _____

Phone/Cell Number: _____ Fax Number: _____

Previous Names: _____

AUTHORIZED REPRESENTATIVE:

I appoint the individual named below to act on my behalf as my Authorized Representative with JSSA. This authorization does not provide my authorized representative with any authority, either implied or direct, over any treatment or direct care decisions. I allow this person to discuss protected health information about me, file a grievance, fill out necessary forms, and submit requests to release personal health information about me to third parties. **See Special Records Below*

Representative Name: _____ Date of Birth: _____

Address: _____

Phone/Cell Number: _____ Fax Number: _____

REASON FOR DESIGNATION: _____

_____

_____

SPECIAL RECORDS: By initialing any of the boxes below, I am authorizing these records/information to be shared with my authorized representative or by my authorized representative to third parties. Initialing these boxes is not a representation that such information exists.

☐ Mental Health Records

☐ HIV/AIDS Related Records _____ Signer must initial

☐ Sexual Abuse/Assault Counseling Records

☐ Substance Abuse and Alcohol Treatment Records

°This appointment of Authorized Representative and authorization to disclose is effective upon JSSA's receipt of a fully completed and signed original or exact copy of this form at the address stated below.

°This appointment and authorization will expire one (1) year after the date this request was signed, unless revoked or an earlier date is entered below.

☐ I would like this appointment and authorization to expire on this date: _____

°I understand that I may revoke this appointment and authorization at any time by giving written notice of my revocation to JSSA at the address stated below. I understand that revocation of this appointment and authorization will not affect any action you took in reliance on this appointment and authorization before you received my written notice of revocation.

°I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

LIMITS OF DISCLOSURE: I understand that I have the right to limit the information under this authorization. Any such limitations must be described below. I understand that by leaving this section blank, I am creating no limitations on disclosure, other than that described in Special Records above.

_____

_____

I have had full opportunity to read and consider the contents of this authorized representative appointment, and I understand that, by signing this form, I am confirming my authorization of the disclosure of my protected health information, as described in this form. I have a right to a signed copy of this authorization.

Individual's Signature (or Legal Guardian, if applicable*) _____ Date Signed: _____

Print Name of Legal Guardian, if applicable* _____ Relationship to Client: _____

**If a legal guardian signs for an individual, a copy of the guardian appointment document must be submitted with this form.*

Send completed and signed forms to:

**Retain a copy for your records*

JSSA CONTACT INFORMATION

Attention to: _____

Address: _____

Phone/Fax: _____

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