**Consent Form for Appointed Representative to Access and Discuss Medical Information**

**Purpose:**  
This form is to obtain your consent to allow a designated representative (e.g., family member, friend, or legal guardian) to discuss your medical information with our office. By signing this form, you authorize the appointed representative to access and discuss details related to your healthcare, including appointment times, test results, and specialist referrals. The form also outlines potential risks associated with this authorization.

**Appointed Representative Information:**

Name of Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Scope of Authorization**

I authorize my appointed representative to access and discuss the following types of information with the office:

1. **Appointment Scheduling:**
   * Discuss and schedule appointments on my behalf, including regular office visits, specialist appointments, and follow-up care.
2. **Test Results and Medical Information:**
   * Access and discuss my medical test results (e.g., blood tests, imaging, etc.) and other health information as needed for coordination of my care.
3. **Specialist Referrals and Treatment Plans:**
   * Obtain information regarding specialist appointments, referrals, and my treatment plan, and communicate with healthcare providers involved in my care.
4. **Billing and Insurance Information:**
   * Discuss billing inquiries, insurance matters, and claims on my behalf.

**Potential Risks of Appointing a Representative**

1. **Confidentiality and Privacy Risks:**
   * By authorizing a representative to access your medical information, you are sharing personal health information (PHI) with someone other than your healthcare provider.
   * Your appointed representative may have access to sensitive health information that could include details about your diagnosis, treatment, or test results.
   * There is a potential risk that your representative may inadvertently disclose your medical information to third parties without your consent, especially if they share information verbally or via unsecured methods (e.g., phone, email).
2. **Miscommunication:**
   * There is a risk of miscommunication between your appointed representative and healthcare providers, which could lead to misunderstandings or delays in your care.
   * Your representative may not fully understand or relay medical information correctly, which could impact your treatment or decisions regarding your healthcare.
3. **Inaccurate Representation of Preferences:**
   * Your appointed representative may make decisions or convey information that does not fully reflect your preferences or wishes, particularly in complex or sensitive healthcare situations.
   * You are responsible for ensuring that your representative understands your preferences for your healthcare.
4. **Revocation of Authorization:**
   * If you decide to revoke this authorization, there may be a delay in communicating this decision to the office and your representative. Until the revocation is processed, your representative may continue to access your medical information.

**Patient Responsibilities**

* You are responsible for ensuring that your appointed representative is someone you trust to manage your healthcare information responsibly.
* You must notify the office of any changes to your appointed representative, such as replacing the representative or updating their contact information.
* You may revoke this authorization at any time by submitting a written request to the office.

**Revocation of Authorization**

This authorization remains in effect until revoked by the patient in writing. To revoke this consent, contact the office using the information provided below.

**Consent for Appointed Representative to Access Medical Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient Name), have read and understand the potential risks associated with allowing my appointed representative to access and discuss my medical information. I give my informed consent for the representative named above to communicate with the office regarding my healthcare, including appointments, test results, treatment plans, and billing information.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointed Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent form ensures that you are informed about the risks of appointing a representative to manage your medical information and helps maintain transparency in how your healthcare will be managed.