Patient Representative Authorization/Proxy Form

This form allows you to choose a patient representative (a designated person authorized by you) that allows Family First Primary Care to disclose/share your medical Information. (Example: Spouse, Parent, Family member, or any person of your choice) You may place limitations on the type of information that is to be disclosed, or choose not to select a representative.

- PATIENT NAME: ____
  (Please print clearly)

- PATIENT DOB: ____

Please check one:

☐ **I DO NOT wish to select a patient representative at this time.**

☐ **I DO wish to select a patient representative at this time.**

I ________________________ designate ____
(State relationship to patient) _________________________ as my representative. My signature below acknowledges that I give my authorization for Family First Primary Care, PLLC to disclose any and all medical information pertaining to my care to the above named representative.

***Please indicate any restrictions/limitations of medical information to be shared with your representative:**

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My designated representative can be reached:
Phone (Home) _________________ Work __________________

__ I have reviewed and I understand this form.
__ I understand that I can withdraw my consent in writing at any time.

Patient Signature: ______________________________________ Date: _______________