1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Designation of Authorized Representative

Patient's Name:_______________________________________ Birth date:____________________

Address:____ Phone No.:___________________

City/St/Zip:____ SSN: XXX-XX-_________________

Under the Health Insurance Portability and Accountability Act (HIPAA), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing Sparrow Health System (or _________________________________) of your wish to designate the named person(s) as your authorized representative(s). You may revoke this designation at any time by signing, with date and time, the revocation section of your copy of this form and returning it to Sparrow Health System Privacy Department (or __________________________) at the address at the top of this form.

I, ____ (print name) hereby nominate the following person(s) to act as my authorized representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

____
Print name of authorized representative

____
Print name of authorized representative

☐ The authority of this person or persons when acting as my authorized representative is restricted to the following functions:

Description: ____

____

____

☐ My designated authorized representative(s) is (are) afforded all of the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Sparrow Health System Privacy Department (or ______________________________) at the address above. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my protected health information have already acted in reliance on this designation.

_____________________________________ _________________
Signature of patient Date & Time

Complete only if patient or representative signs by use of a mark:

____
Printed name of witness

_____________________________________ _________________
Signature of witness Date & Time

____
Printed name of witness

_____________________________________ _________________
Signature of witness Date & Time

Scan this document to patient chart and return original to Authorized Representative.

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow has verified the identification of ______________________________________ (patient's authorized representative name) by ____ (type of verification, e.g., driver's license) and that in his/her capacity of __________________________________(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

____ ___________________
Caregiver name and signature Date & Time

REVOCATION SECTION

I hereby revoke this designation of an authorized representative.

____ ___________________
Signature of patient Date & Time

Complete only if patient or representative signs by use of a mark:

____
Printed name of witness

____ ___________________
Signature of witness Date & Time

____
Printed name of witness

____ ___________________
Signature of witness Date & Time

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow has verified the identification of ______________________________________ (patient's representative name) by ____ (type of verification, e.g., driver's license) and that in his/her capacity of ___________________________________(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

____ ___________________
Caregiver name and signature Date & Time