



Request to Designate a Personal Representative to Have Access to Records

Section 1: Patient's Personal Information

Name: _____ DOB: _____
 Address: _____ Telephone: _____

I understand that upon granting access to requested records, the Company will update our records within thirty (30) days of receipt of request. This request will remain in effect for the designated individuals until such time as a Request for Restriction of Uses and Disclosure is received. The Company will retain PHI records and associated documents for six (6) years from the date of last action.

Section 2: Authorization to Designate Personal Representatives to Access Your Protected Health Information

Name	Relationship/DOB	Address

*I am **AUTHORIZING** the individual(s) listed above to have access to my Protected Health Information (PHI) and they may request PHI, limited data sets or any other information or document. My signature indicates my authorization for PHI to be released to myself and/or to the designated individuals listed above.*

ONLY PATIENT MAY SIGN:

Date: _____ Signature: _____ Relationship to Individual: _____

Date: _____ Witness Signature: _____

Submit this completed request to the Company or mail to:

AnewHealth
 ATTN: Privacy Officer
 8333 Rockside Road
 Valley View, OH 44125-6126

Office Use Only – Please Do Not Write Below This Space

Date Request Received: _____ By: _____

Notice of Approval Mailed Notice of Denial Mailed