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# AUTHORIZATION FOR ADULT PROXY TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

*This form is to be completed by a patient over the age of eighteen who wishes to grant another adult proxy access to their current and future medical records, including billing records, in both written and verbal format.*

Patient Information

Patient Name: _____Date of Birth: _____

Address: _____State: _____Zip: _____

Phone Number: _____

Other Names under which patient has been treated: _____

Adult Proxy Information
Must be over 18 years of age.

Proxy's Name: _____ Date of Birth: _____

Phone Number(s): Mobile: _____ Home: _____

Relationship to Patient: __ Adult Child ___ Spouse/Partner ___ Parent/Guardian ___ Other

I hereby authorize Idaho Gastroenterology Associates and any of its affiliated entities, employees, agents, or associated health care practitioners to allow the above-named individual to access my protected health information as my designated proxy. I **understand that this authorization will remain valid and in effect until affirmatively revoked** by me.
I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must submit a written revocation to Health Information Management (Medical Records) at any Idaho Gastroenterology Associates facility. I understand that information disclosed by Idaho Gastroenterology pursuant to this authorization may be redisclosed by the individual that receives this information and may no longer be protected by privacy regulations. I understand the information that my proxy will be able to access may include records related to
behavioral and mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. I also understand that my health care cannot be conditioned upon my execution of this authorization.

Signature of Patient _____Date_____

8/2023