PHILLIP R. BOWDEN, M.D., PA
MID-SOUTH GASTROENTEROLOGY GROUP
PATIENT REPRESENTATIVE IDENTIFICATION FORM

Date: _____

Patient Name: _____ Chart # _____

By law, the HIPAA Privacy Rule prohibits Clinic/Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. This Rule became effective April 14, 2003.

1) Please list the names of all persons that you wish to have access to your Protected Health Information (PHI).

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

2) Please list the name of the person(s) with whom we can discuss your bill.

Name: _____ Relationship to Patient: _____

3) If applicable, please list the name of your Legal Representative.

_____ Closest Relative

_____ Guardian

_____ General Power of Attorney

_____ Health Care Power of Attorney

PLEASE NOTE: In order for us to disclose your PHI, the above representatives must be able to provide two (2) of the three (3) identifiers listed below.

1 patient's social security number
2 patient's date of birth
3 patient's full legal name

_____ _____

Patient's signature Date