Good Samaritan Hospital
Westchester Medical Center Health Network

ACCESS TO PROTECTED HEALTH INFORMATION AUTHORIZATION

Name of Patient: ________________________________

I hereby assign the person below as the Caregiver: ☐

Name	Relationship to Patient	Address	Telephone

I hereby decline assigning any Caregiver: ☐

<u>"CAREGIVER"</u> shall mean any individual duly identified as a caregiver by a patient under this article who provides after-care assistance to a patient living in his or her residence. An identified caregiver shall include, but is not limited to, a relative, partner, friend or neighbor who has a significant relationship with the patient.

Patient Name (Print) ____________________________ Date/Time ______________________

Patient Signature: ____________________________ Date/Time ______________________

OFFICE USE ONLY:

☐ Patient is unable to provide consent due to condition

☐ Patient refused to sign

____________________________________ ____________________________________

Hospital Staff Person's Name Date & Time