



ACCESS TO PROTECTED HEALTH INFORMATION AUTHORIZATION

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Name of Patient: _____

I hereby assign the person below as the Caregiver:

Table with 4 columns: Name, Relationship to Patient, Address, Telephone. It contains three empty rows for data entry.

I hereby decline assigning any Caregiver:

“CAREGIVER” 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