Protected Health Information Designee

Patient Name: _____ Date of Birth: _____

I understand that the individuals identified below will be treated by Sonoma Valley Community Health Center as individuals involved directly in *my care or my childs care*, and as such Sonoma Valley Community Health Center, will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments and all other functions normally associated with individual patient care, payment, and health care operations

Name of Designee: _____ Designee Date of Birth:_____

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I understand that the above named designees have a right to request and receive a Notice of Privacy Practices from Sonoma Valley Community Health Center.
This document is an acknowledgment that the above named patient or the patient's legal guardian has supplied Sonoma Valley Community Health Center (SVCHC) with one or more contacts, with whom they may use or disclose the patients personal health information. SVCHC has made the Protected Health Information Designee available to parents so that they may identify those individuals that could possibly provide assistance in providing health care treatment to minor children.

By signing below, I acknowledge that I have read and understand the above statements and accept the terms.
I voluntarily sign this authorization, and understand that my ability to receive health care from Sonoma Valley Community Health Center will not be affected if I refuse to sign this authorization.

Patient Signature/Parent/Legal Guardian Signature: _____
Date _____

☐ *I decline to provide a protected health information designee contact for myself or my child at this time.*

Patient Signature/Parent/Legal Guardian:_____
Date_____

Implemented 1/2/2014