

Personal Representative 2 (Please Print Clearly)

Full Name: _____ Phone Number: _____

Relationship to You: _____ (such as: spouse, parent, child, friend, etc.) Date of Birth: _____

Restrictions: _____

This authorization to release information to my Personal Representative will automatically expire in three (3) years after the date of my last visit to Foothill Family Clinic.

I understand that I have the right revoke or end this authorization at any time. I understand that, if I do not wish any person named above to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Officer at the address shown below. I understand that my revocation of this authorization will not affect any action that has been taken or information that has already been released, based upon this authorization, before receiving my request to revoke authorization.

Privacy Officer
Foothill Family Clinic North
2295 S Foothill Drive
Salt Lake City, UT 84109
(801) 486-3021

Privacy Officer
Foothill Family Clinic South
6360 South 3000 East, Suite 100
Salt Lake City, UT 84121
(801) 365-1032

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that Foothill Family Clinic may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature: _____ Date: _____

Complete and sign this form. You are entitled to a copy of this complete form.