RELIANT MEDICAL GROUP
Part of Optum®

Patient Representative Release Authorization

By filling out this form and signing below:

I give Reliant Medical Group permission to review my health history with my patient representative(s) (listed below). I understand this may include sensitive details, such as:

- Transmissible illness testing and/or treatment, including HIV/AIDS
- Drug and alcohol abuse
- Behavioral and mental health issues

This permission will only expire if I cancel or change it. I can cancel or change it at any time. Changes must be made in writing and sent to Reliant Medical Group at the address on this form. I understand that changes or cancellations:

- Will not affect information already shared with my representatives
- Will not begin until Reliant Medical Group receives my written request

If I want to change my representative(s), I must complete a new form. I understand that when I fill out a new form, my old form is no longer valid. My representative(s) can't share information without my permission. If they share without my permission, federal law may not protect those actions.

I agree to let Reliant Medical Group talk to my representative(s). I do not need to sign this form to make sure I get treatment.

My Information (Patient)

Name:_____ Date of Birth:_____

Street:_____

City:_____ State:_____ Zip:_____

Patient Representative(s): Please list individuals to be your patient representative. Staff will ask for your name and date of birth before speaking with your representative. Please make sure he/she has this information.

1. Representative's Name: _____

   Relationship to Patient: _____ Telephone #: ( ) _____ - _____

2. Representative's Name: _____

   Relationship to Patient: _____ Telephone #: ( ) _____ - _____

3. Representative's Name: _____

   Relationship to Patient: _____ Telephone #: ( ) _____ - _____

I understand by signing below I give permission to Reliant Medical Group to talk to my representative(s) listed above about my health information without restrictions.

X_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

Please mail this form to the HIM department or call for questions about this form:

Reliant Medical Group HIM Department
385 Grove Street, Worcester, MA 01605
(508) 721-1142