

**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 I understand that when I fill out a new form, my old form is no longer valid.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