CORNERSTONE FAMILY HEALTHCARE
845-563-8000 • www.cornerstonefamilyhealthcare.org

Patient Representative Form

Patient Name: ____ Date of Birth: ____/____/_____

Patient Representative Information:

This permits Cornerstone Family Healthcare to allow____,

As a designated below, to be present in the examination room, and I give permission to Cornerstone Family Healthcare, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including , but not limited to my protected health information, and to discuss all payment issues, with such individual.

- **THIS FORM DOES NOT SERVE AS A NEW YORK STATE HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY.**

Representative information: (Representative must be over the age of 18 years)

Name of the individual: ____

Date of Birth: ____________________ Telephone #:____

Address: ____

Relationship to the Patient: ____

- A separate authorization must be completed to share highly sensitive information, such as HIV, alcohol and substance abuse treatment, or mental health information.

- **THIS DOES NOT GRANT THE PATIENT REPRESENETATIVE THE RIGHT TO ACCESS PRINTED MEDICAL CHARTS OR INFORMATION AND DOES NOT GIVE THEM THE RIGHT TO REQUEST THEM ON THE PATIENTS BEHALF**. In order to revoke the rights of the Patient Representative to discuss or otherwise access your PHI a revocation must be submitted to Cornerstone Family Healthcare.

Patient Signature: ____ Date: ___________________