AUTHORIZED PATIENT NOTIFICATION LIST

(Required of HIPAA) Health Insurance Portability and Accountability Act

I authorize all WesterWell Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my healthcare, to include: appointments, tests, test results, surgical procedures, prescriptions and any other pertinent information with the following persons in order to facilitate and coordinate my care, treatment and payment:

NAME	Relationship	Phone Number(s)
NAME	Relationship	Phone Number(s)
NAME	Relationship	Phone Number(s)
NAME	Relationship	Phone Number(s)

☐ I do not want to designate anyone to have authorization at this time.

This document will be a part of your permanent record. In the event any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

PATIENT'S NAME PRINT	SIGNATURE	DATE
LEGAL GUARDIAN/OTHER AUTHORIZED PERSON PRINT	SIGNATURE	DATE