Clackamas & Oregon Pediatrics: AUTHORIZATION OF DELEGATE - Adult

Patient Name: _____ **DOB:** _____ ***EMR:***

❒ I authorize the following delegate(s) to act on my behalf regarding my healthcare.

❒ **I decline**. Do not discuss my care with anyone other than me, except as mandated by HIPAA. *Subject to CPC/OP privacy policy.*

Signed: _____ Date: _____

I wish to delegate the person(s) below in the following matters:

- ❒ To schedule, confirm and cancel appointments,
- ❒ To speak to CPC/OP staff regarding my care and treatment,
- ❒ To speak to CPC/OP staff regarding my bill,
- ❒ To pick up my prescriptions, medical records, or medical equipment from CPC/OP,
- ❒ Other: _____

Person(s) authorized: (*Please note, person must be 18 or older and present photo ID at each visit*)

Name: _____

Relationship to patient:_____ Phone #: _____

Effective until (mm/dd/yyyy) _____ or until revoked in writing, whichever occurs first.

Name: _____

Relationship to patient:_____ Phone #: _____

Effective until (mm/dd/yyyy) _____ or until revoked in writing, whichever occurs first.

Name: _____

Relationship to patient:_____ Phone #: _____

Effective until (mm/dd/yyyy) _____ or until revoked in writing, whichever occurs first.

Please list your PREFERRED METHOD OF COMMUNICATION:

1. _____
Circle: Home Phone/Cell Phone/Text/Email

2._____
Circle: Home Phone/Cell Phone/Text/Email

PERMISSION TO LEAVE DETAILED MESSAGE

I authorize practitioners and staff of CPC/OP to leave detailed voice, text or email message(s) when contacting me via one or more of the preferred methods of communication listed above.

Effective until (mm/dd/yyyy) _____ or until revoked in writing, whichever occurs first.

☐ **I decline.** Except appointment reminder messages, do not leave detailed voice messages.