TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO

Personal Representative Request

Patient Name: _____

MRN: _____

DOB: _____

Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) values the privacy of its patients and is committed to its practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC El Paso will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

- ❑ Permission to receive or access protected health information or leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, or the last four digits of the patient's Social Security number.

  Name:_____Relationship: _____ Phone #: _____

  Name:_____Relationship: _____ Phone #: _____

  Name:_____Relationship: _____ Phone #: _____

- ❑ Permission to call the following numbers to leave messages (without disclosing protected health information): **Please note that TTUHSC El Paso cannot leave specific test results or details of the patient treatment by voice mail due to our concern for patient's privacy.**

  Phone #:_____ Phone #: _____

- ❑ Permission to use email address for the purpose of providing information about the online patient portal and general information about TTUHSC El Paso.

  Email address: _____

Please complete the following questions for security purposes; staff may ask these questions if there are any concerns about releasing the patient information. **Please provide at least one answer.**

1. What is your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date	**Print Your Name** **(Person signing consent form)**	**Signature** **(Patient or Other Legally Authorized Person)**

Relationship to Patient