Consent for Release of Information & Authorization for Representation

This form **must** be completed if you are filing a complaint **on behalf of the patient**. Please choose from the options below that best describes your authority.

The investigation process generally requires the collection of the patient's personal and confidential health information. CPSNL requires documentation confirming your authority to represent the patient and receive such information on their behalf.

Patient's Full Name:_____

MCP #:_____ Date of Birth:_____
(or Health Care #) (Month/Day/Year)

Complainant's Signature:_____ Date:_____

1. The patient is a child

☐ I am the child's parent and have legal custody of the child (No further documentation in required).

☐ I am the child's legal guardian. **I have attached copies of the relevant legal documents.**

Patient's Signature:_____ Date:_____
(Age 12+ only, if applicable)

2. The patient has asked me to file on their behalf

☐ The patient is fully capable to file a complaint, but has asked me to file this complaint on their behalf.

To allow you to file the complaint, the patient must provide the following consent:

- I understand that my representative will be considered the complainant for the purposes of processing this complaint.
- I understand that my representative may receive details concerning my personal health information during the investigation of this complaint and that CPSNL will communicate only with my representative unless I state otherwise.
- I understand that I can withdraw or limit this authorization at any time by providing written notice to CPSNL.

Patient's Signature:_____ Date:_____

3. The patient is not capable to represent themselves

☐ The patient is deceased. I have the legal authority to represent the patient. **I have attached copies of the relevant legal documents** (e.g., letters of probate/administration, last will and testament, etc.)

☐ The patient is incapable. I have the legal authority to represent the patient. **I have attached copies of the relevant legal documents** (e.g., power of attorney, letters of guardianship, etc.)

☐ The patient is unable to represent themselves and I do not have the legal authority to represent them, but their legal representative has authorized me to act as the representative for the purposes of this complaint.

Patient's Legal Representative:_____
(Please Print)

Signature of Patient's
Legal Representative:_____ Date:_____