Roommate Authorization to Disclose Protected Health Information
Authorized Electronic Monitoring Device

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

Name of Facility: _____

Street Address: _____

City: _____ State: ND **Zip Code: _____**

I hereby authorize the facility listed above and any and all my current and future medical and healthcare providers to disclose to:

_____
(Name of Resident or Resident Representative Utilizing the Authorized Electronic Monitoring Device)

The following Protected Health Information: My likeness (video, audio, photograph) and any and all information regarding my past, present, or future physical or mental health that is individually identifiable that may be captured, recorded, maintained or transmitted by the authorized electronic monitoring device. This includes but is not limited to, information such as symptoms, diagnoses, treatments, prognosis, lab results, other test results, medications, durable medical equipment, and information regarding insurance, claims, and payment.

For the purpose of permitting my roommate or roommate's resident representative to conduct authorized electronic monitoring in our shared room.

Duration/Revocation: This authorization is voluntary and remains in effect for one year from the signature date. I may revoke this authorization by providing written notice to the facility named above, at any time. Revocation will not apply to disclosures of Protected Health Information that occur before the written revocation notice is received by the facility. A photocopy of this authorization is as effective as the original.

Treatment, payment, enrollment, or eligibility for applicable health benefits will not be conditioned upon my providing this authorization unless otherwise required by law. Any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.

Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. I have a right to receive a copy of this authorization.

_____ _____

Signature of Resident Date

Resident Representative: If you are signing this authorization on behalf of the resident, documentation demonstrating your authority must be on file with the facility or attached to this document.

_____ _____

Signature of Resident Representative (if applicable) Date

Type of Authority: ☐ Power of Attorney for Healthcare **OR** ☐ Guardian