The Elliot

A Member of SOLUTIONHEALTH

Manchester, New Hampshire

Patient Authorized Liaison (PAL)

Patient Information

The PAL program at Elliot Health System (EHS) allows patients to designate a person with whom we can communicate important healthcare information if a need should arise. This liaison could be a family member, friend, or other person who is contacted if the patient is unable to be reached or is unable to discuss a question related to their care.

You are not required to designate a PAL in order to receive care at EHS. The law does not require your healthcare provider to obtain written permission before sharing or discussing your health information with family, friends, or others who may be involved in your care or payment for care. If you have not designated a PAL ahead of time, your healthcare provider may use his or her professional judgment if necessary (for example, in case of emergency).

What a PAL can do . . .

- ✓ A PAL can help with tasks like appointment scheduling, cancellations, prescription refills, and specialist referrals.
- ✓ A PAL can contact your healthcare provider regarding test results, follow-up instructions, and treatment plans.
- ✓ A PAL can communicate with your healthcare provider face-to-face, over the telephone, or in writing to coordinate aspects of your medical treatment or payment.

What PAL cannot do . . .

- ✗ A PAL cannot make any healthcare decisions for you, unless otherwise permitted by law. A PAL is not the same as a durable power of attorney (DPOA), guardian, healthcare proxy, or other type of legal representative.
- ✗ A PAL cannot access or request a copy of your medical record. Your PAL cannot authorize any uses or disclosures of your health information that are not otherwise permitted by law or that require your specific written authorization.
- ✗ A PAL cannot sign any consent forms or other legal documents on your behalf. Designating a PAL does not limit your financial responsibility for payment of medical bills.

Would you like to designate a Patient Authorized Liaison (PAL)?

❑ Yes, I authorize_____ Relationship_____ Phone_____

❑ Yes, I authorize_____ Relationship_____ Phone_____

If you wish to limit or restrict a PAL's access to your personal information, please list any exceptions/ exclusions in the space provided:

_____

_____

❑ No, thank you. I do not wish to designate a PAL at this time.

Patient Signature_____ Date _____

Witness Signature _____ Date _____

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