

Designated Individuals Authorization

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment or payment. I understand that the identity of designated parties must be verified prior to the release of any information.

Authorized Designees:

Spouse: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Signature

Date