Designated Individuals Authorization Form

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 and payment. I understand that the identity of designated parties must be verified before the release of any information. If not otherwise informed, the following Authorized Designees will be able to access the above referenced information indefinitely.

Authorized Designees:

Print Name: _____ Relationship: _____

Print Name: _____Relationship: _____

Print Name: _____Relationship: _____

Print Name: _____Relationship: _____

_____
Patient Name

_____ _____
Patient Signature Date