
Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties 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.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date