****

**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 the designated party/parties must be verified before the release of any information.

Patient name:

Authorized Designees:

Name: Relationship:

Name: Relationship:

Name: Relationship:

Name: Relationship:

Print name (If the patient is a minor, parent/guardian’s name and relationship)

Signature Date