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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

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

AUTHORIZED DESIGNEES:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date