Name: _____

DOB: _____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, _____ give my authorization to release my medical information including results of my laboratory test, ultrasound and/ or other results to my representative(s).

Patient Initials

_____ My spouse (Name)_____

_____ My child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May be left on my answering machine at home

_____ May be left on my answering machine at work

_____ May be left on my cell phone _____

_____ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF**

_____ **Date**: _____

Patient Signature