

**Designation of Individuals Who are Involved in My Payment or Treatment Decisions**

In order to comply with federal privacy laws, the \_\_\_\_\_ (name of clinic)\_\_\_\_ ("Clinic") may provide limited information about you to individuals who may be involved in your treatment or payment decisions, unless you object to sharing this information.

The Clinic requests that you list on this form the people you authorize to receive your health information (**e.g. family members or others who accompany you to appointments or who call the Clinic on your behalf**). Please provide the full names of these individuals in the lines below, the relationship to you and whether they are involved in decisions related to your treatment and/or payment. You do not need to list yourself, if you are the patient.

I authorize the Clinic to disclose information related to my treatment or payment obligations to the people listed below.

**Please enter the information requested and check the appropriate box to indicate whether the individual is involved in your payment and/or treatment decisions.**

Individual's Full Name (Please print)	Relationship to Patient	Involved in Payment (Check if Yes)	Involved in Treatment (Check if Yes)

This information will be presumed valid and the Clinic may rely on it until you have notified the Clinic in writing of any changes to this form. Notification of a change in the above information provided by you, should be sent to \_\_\_\_\_ (name and address of clinic)\_\_\_\_.

\_\_\_\_\_  
Full Patient Name (printed)

\_\_\_\_\_  
Legal Representative (printed) *if applicable*

\_\_\_\_\_  
Patient or Legal Representative (signature)

\_\_\_\_\_  
Signature Date