COASTAL MEDICAL CLINIC P.C.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I HEREBY AUTHORIZE ONE OR ALL OF THE DESIGANATED 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 INFROMATION.

Authorized Designees:

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

Patient Name (print) :_____

Patient Signature: _____

Date: _____