DESIGNATED RELATIVE

I authorize discussion of my general medical and diagnosis (including treatment, payment, and health care operations with:
Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency.

NAME	*RELATION*	*PHONE*

*Signature:*_____ *Date:*_____

*Patient Name:*_____ *Date Of Birth:*_____

Cancelation of Designated Relative

I do not authorize discussion of my general medical and diagnosis (including treatment, payment, and health care operations with:
Please list the family members or significant others, if any, whom we won't inform about your medical condition, in case of an emergency.

NAME	*RELATION*	*PHONE*

*Signature:*_____ *Date:*_____

Patient Name: _____ *Date Of Birth:*_____

State of Florida
County_____

The foregoing instrument was acknowledged before me this _____ day of _____,20____ by _____

_____ who was producer_____ as identification.

SIGNATURE_____

12142 Cortez Blvd, Brooksville FL. 34613
17210 Camelot Court, Suite 102, Land O lakes, FL, 34638
Tel & Text (352) 596-9095 Mobile: (352) 263-5447 Fax: (352)578-1032

INITIALS _____