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**Liberty Doctors, LLC dba Ebb Tide Comprehensive Care**

**Designated Party Release**

You may give Liberty Doctors, LLC dba Ebb Tide Comprehensive Care written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information, such as results for labs, x-ray, prescription refills, and appointment reminders, on your home answering machine, voicemail at work, cell phone, email or with another party you designate.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account/Chart#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **Liberty Doctors, LLC dba Ebb Tide Comprehensive Care** to disclose my Protected Health Information (PHI) to the following individuals:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **Liberty Doctors, LLC** to communicate my Protected Health Information (PHI) to me via the following methods:

\_\_\_\_\_ Detailed message on my home phone answering machine Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Detailed message on my voicemail at work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Detailed message on my cell phone voicemail Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Research Organization Studies

 We may use or disclose medical information about you to research organizations if the organization has

 satisfied certain conditions about protecting the privacy of your medical information.

**Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**