Pavilion Family Physicians

HIPAA Designated Individuals Authorization Form

For Someone Other Than Yourself

I hereby authorize one or all of the designated parties listed 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 prior to the release of any information.

Authorized Designees:

Name: _____ **Relationship**: _____**Phone**: _____

Name: _____ **Relationship**: _____**Phone**: _____

Name: _____ **Relationship**: _____**Phone**: _____

Name: _____ **Relationship**: _____**Phone**: _____

This authorization is valid (**MUST CHOOSE ONE**):

☐-Indefinitely ☐-1 year ☐-Other (must specify) _____

Patient Name: _____ Signature: _____ Date: _____