

**AUTHORIZED PERSON LIST**

Persons listed may receive my protected health care information to the extent noted. In order for them to gain access via telephone, I understand that they will be required to give the last four digits of my social security number and answer other questions to assure their identity.

**Authorized Person:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

- ( ) Full authorization (may authorize release to third parties)
- ( ) Authorization with the following restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorized Person:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

- ( ) Full authorization (may authorize release to third parties)
- ( ) Authorization with the following restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorized Person:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

- ( ) Full authorization (may authorize release to third parties)
- ( ) Authorization with the following restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorized Person:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

- ( ) Full authorization (may authorize release to third parties)
- ( ) Authorization with the following restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient / Authorized Name:**

Print \_\_\_\_\_

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

