Protected Health Information Designee Form

I understand that Scarsdale Medical Group may release protected health information to a designated family member, friend or other person involved in my care. I am designating the following person(s) listed below, as a person(s) involved in my health care or payment for my health care. I am circling 'yes' for the type of information that I am allowing you to share with each designee. I understand that I may object to sharing all, some, or specific information with anyone listed here and will indicate such on the lines provided below for that purpose.

Your protected health information includes your medical and billing records maintained by Scarsdale Medical Group.

Patient Name: _____ **Date of Birth:** _____

Address: _____

I authorize Scarsdale Medical Group to disclose my PHI to:

1. Name: _____ Phone #: _____

   Relationship to patient: _____
   I want to share: Health Information (Yes/No) Billing Information (Yes/No)

2. Name: _____ Phone #: _____

   Relationship to patient: _____
   I want to share: Health Information (Yes/No) Billing Information (Yes/No)

3. Name: _____ Phone #: _____

   Relationship to patient: _____
   I want to share: Health Information (Yes/No) Billing Information (Yes/No)

Please indicate any specific information that should not be shared with any of the contacts listed above.

_____

_____

SIGNATURE: _____ _____
Signature of Patient or Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, relationship to patient: _____