

DESIGNATED INDIVIDUALS AUTHORIZATION FORM
For the Practices of
Darrell Belcher, Philip Branson, Robert Kropac, & Frederick Morgan

I hereby authorize one or all of the designated parties 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 before the release of any information.

Authorized Designees:

Name:	_____	Relationship:	_____
Name:	_____	Relationship:	_____
Name:	_____	Relationship:	_____
Name:	_____	Relationship:	_____

Patient Name

Signature

Date