MRN: _____

EVMS Medical Group
Involvement in Care – Patient Designation

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone #: _____

DESIGNATION SECTION

I hereby request that the following person(s) be allowed to participate in my care or payment-decision process. I understand that these person(s) may be given health or payment information about me if I am unavailable or unable to communicate. EVMS Medical Group will act on this information until I revoke or amend this authorization in writing.

NAME	RELATIONSHIP	DATE OF BIRTH	PHONE #

EVMS Medical Group and its affiliates will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed protected information.

Patient Signature: _____ Date: _____

Witness Signature: _____

Department_____

Office use only - Patient Revocation/Modification

Date received: _____ *Request received via* □ Letter □ Telephone
Staff initials: _____ *(Attached copy of any written correspondence)*

Revised 2/2017