EVMS
PSYCHIATRY AND
BEHAVIORAL SCIENCES

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/Guardian Signature: _____ Date: _____

Witness Signature: _____

Department: EVMS Psychiatry & Behavioral Sciences

Office use only - Patient Revocation/Modification

Date received: _____
Staff initials: _____

Request received via ☐ Letter ☐ Telephone
(Attached copy of any written correspondence)

A clinical practice of
EVMS Medical Group

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