ConneXtCare™
A Community of Care

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Form to Designate Representative for Health Care Needs Rev. 12.29.17

Is there anyone involved in your health care or payment for your health care with whom we may share your medical information?

I, ____ Date of Birth______________________designate
(Your Name)

1) Name________________________ Relationship to Patient_______________________

Address________________________

City, State, Zip___________________

Phone Number___________________

2) Name________________________ Relationship to Patient_______________________

Address________________________

City, State, Zip___________________

Phone Number___________________

To act as my representative in the following situations by initialing on the corresponding line:

__________________Test results

__________________Medication questions/refills

__________________Schedule/Cancel Appointments

__________________Financial

__________________Medical Records (Pick- up only)

Signed____ Date________________________

Please print name and relationship if patient is a minor____

Witness Signature ________________________

This form may be revoked at any time and will be updated each calendar year.