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Designation of Personal Representative

I, _____, _____, allow the following
(Patient Name) (Date of Birth)

individual(s) access to my scheduling and account information.

Name

Daytime Phone

Patient/Guardian Signature

Date

Designation of Personal Representative is valid until revoked by patient.

Revocation of Designation of Personal Representative

I, _____, revoke my designation of Personal
Representative(s) specified above.

Patient/Guardian Signature

Date