Attachment C

CAREGIVER DESIGNATION & AUTHORIZATION

The undersigned, a patient at the Practice ("You"), designate one or more Caregivers and authorize such Caregiver(s) to engage with the Practice on Your behalf as follows:

Caregiver Designation: You desire to designate the individual(s) listed below as Your Caregiver(s) for purposes of assisting with and facilitating the Services You receive from the Practice:

1. ______________________________ Relationship to You: ______________________

Caregiver Name (Print) Phone Number: ________________________

E-mail Address: ________________________

2. ______________________________ Relationship to You: ______________________

Caregiver Name (Print) Phone Number: ________________________

E-mail Address: ________________________

3. ______________________________ Relationship to You: ______________________

Caregiver Name (Print) Phone Number: ________________________

E-mail Address: ________________________

Scope of Caregiver Authority: You authorize the Caregiver(s) to assist with, participate in, and facilitate all aspects of Your participation as a patient in the Practice, including, but not limited to, the following activities:

1. Scheduling appointments for You.
2. Attending consultations.
3. Communicating with the Practice through E-communications, including cellular messaging and/or e-mail messaging, as authorized by the Physician-Patient EMail Disclosure & Consent.
4. Accessing, amending, and updating information in Your medical records maintained by the Practice.
5. Assisting with or making payments on behalf of You.

Authorization to Disclose PHI: You authorize the Practice to disclose Your Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), to the Caregiver(s) You have designated herein for the purposes outlined in this Caregiver Designation & Authorization form.

Right to Modify or Rescind: You are not required to designate any Caregiver(s) in order to participate in the Practice. You may rescind or modify this Caregiver Designation & Authorization form at any time by providing written notice to the Practice.

Patient ("You")

Printed Name: ___________________________________ Date: ______________________

Signature: ___________________________________

If signed by a Legal Representative of a minor patient, complete the following:

1. Print Name: ___________________________________
2. Legal authority: ◻ Parent ◻ Legal guardian