Midwest Eye Care, P.C.
& Midwest Eye Surgery Center, L.L.C.

PATIENT REPRESENTATIVE DESIGNATION FORM

This form allows Midwest Eye Care, P.C. to discuss your protected health information with a person(s) you appoint as your personal representative.

PATIENT INFORMATION	
Name:	Date of Birth:
I authorize release of information to my personal representatives listed below:	
PERSONAL REPRESENTATIVE #1	
Full Name:	Date of Birth:
Relationship:	Phone #:
Please check one: ☐ Release only medical ☐ Release only financial ☐ Release both medical and financial	
PERSONAL REPRESENTATIVE #2	
Full Name:	Date of Birth:
Relationship:	Phone #:
Please check one: ☐ Release only medical ☐ Release only financial ☐ Release both medical and financial	

_____ _____

Patient Signature Date (mm/dd/yyyy)

_____ _____

Witness Signature Date (mm/dd/yyyy)

I AGREE THAT THESE PROVISIONS WILL REMAIN IN EFFECT UNTIL I PROVIDE WRITTEN REVOCATION TO MIDWEST EYE CARE, P.C.

Office use only: Please scan into MedInfo under MR Release