Chase Brexton Health Care
Because everyone's health matters.

THIRD PARTY DESIGNATION FORM

Name of Patient: _____

Date of Birth: _____

Home Address: _____

AUTHORIZATION OF LEGAL REPRESENTATION OF PATIENT

Legal Representative of Patient

Name: _____

Address: _____

I am the: ☐ Guardian or Parent ☐ Legal Custodian ☐ Court-Appointed Representative

☐ Relative _____
(insert relationship to patient named above)

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1. I authorize the following person to consent to all medical care and treatment being provided at Chase Brexton Health Services, Inc ("Chase Brexton Health Care") for the above named patient during the period from _____ to _____. ☐ INDEFINITE

Name: _____

Address: _____

Telephone Number – HOME/CELL: _____

Telephone Number – WORK: _____

Relationship to Patient: _____

OR

2. I consent for the above named patient to attend medical visits on his/her own without being accompanied and consent to the patient's medical treatment for:

☐ this visit only.

☐ future visits through _____ (Date).

☐ all future visits until I specify otherwise in writing.

_____ _____
Signature of Legal Representative Date

Effective: 6/12/2014