HUDSON VALLEY
EYE SURGEONS

DESIGNATION OF PERSONAL REPRESENTATIVE

I authorize Hudson Valley Eye Surgeons, P.C. to speak to the following family members or personal representative regarding:

- ☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis, prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

- ☐ Only the following types of information:

  ____
  ____
  ____

The above medical information shall only be released to the following person(s):

Name of person representative	Relationship	Phone Number	Expiration (**Required**)
____________________________	_____________________	_________________	5yr ☐ 10yr ☐ 15yr ☐
____________________________	_____________________	_________________	5yr ☐ 10yr ☐ 15yr ☐
____________________________	_____________________	_________________	5yr ☐ 10yr ☐ 15yr ☐

I understand that I may terminate this Medical Authorization form by notifying this facility in writing regarding termination and effective date.

____   ____________________________
Patient Name   Date of Birth

____
Signature

____
Date