Raymond M. Thomas, MD, **Gastroenterology/Hepatology**
199 Parrish St., Canandaigua, NY 14424 (585) 394-2520

Friends & Family Designation Form

ONLY people listed on this form are authorized to speak with our office on your behalf.

DESIGNATION:

Please list anyone you may have contact our office on your behalf. (Note that our office will not contact them and will not discuss any issues related to your diagnosis unless you are present.)

I designate the following people as my personal representatives to be involved in my medical care:

Name:	Relationship:	Phone:
1. ____________________	____________________	____________________
2. ____________________	____________________	____________________
3. ____________________	____________________	____________________

List any restrictions related to this request:____

EXPIRATION:

This authorization is in effect as of today's date until revoked.

REVOCATION:

A patient has a right to revoke this authorization, except for anything already done. In order for the revocation to be effective, Raymond Thomas, MD must receive the revocation in writing via hand delivery, US mail, or fax to 394-2524. ALL revocations are not effective until received. The revocation must include:

- The patient's name, address, and date of birth.
- The patient's desire to revoke this authorization, the effective date of the revocation, and the patient's signature.

AUTHORIZATION:

I authorize Raymond Thomas, MD to disclose my protected health information as indicated above. I have read and understand this authorization. I understand that I have the right to revoke this authorization.

PATIENT:

Patient's Signature: ______________________________ OR representative:____________________

Print Name: ______________________________

Date: ____________________