Regional Hand Surgery Associates
Regional Hand Center of Central California
2139 E Beechwood Ave
Fresno, CA 93720
(559) 322-6600
(559) 322-4625 fax

DESIGNATED CONTACT AUTHORIZATION

Regional Hand Surgery Associates/Regional Hand Center of Central California is required by law to maintain the privacy of our patient's health information. With your written approval, we may verbally and electronically disclose your health information to others, including designated family, friends, or others who are involved in your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original. **You may revoke this form in writing at any time.**

Please authorize how you would like us to communicate with you. Check all that apply:
[ ] Mail [ ] Phone [ ] Voice Mail [ ]Email [ ]Text

I, (please print name) _____ authorize the following person(s) to receive verbal information from Regional Hand Surgery Associates/Regional Hand Center of Central California regarding my health care or payment for health care.

PLEASE CHECK ALL THAT APPLY:
[ ] Spouse [ ] Family Member [ ] Friend/Other

_____
_____

1. Description of the information that may be used or disclosed:
   * All health information pertaining to me related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical condition, and any other health related information.
2. I understand that if the person(s) that receives the information described herein is not a health care provider covered by federal privacy regulations, the information described here may be redisclosed by such person and will likely no longer be protected by the federal privacy regulations.
3. If the person completing this authorization is the personal representative of the patient, describe your authority to act on this person's behalf:_____

Signature of Patient/Patient Rep:_____
Date of Birth:_____ Today's Date:_____