

MRN: \_\_\_\_\_

**EVMS Medical Group**  
**Involvement in Care – Patient Designation**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**DESIGNATION SECTION**

I hereby request that the following person(s) be allowed to participate in my care or payment-decision process. I understand that these person(s) may be given health or payment information about me if I am unavailable or unable to communicate. EVMS Medical Group will act on this information until I revoke or amend this authorization in writing.

NAME	RELATIONSHIP	DATE OF BIRTH	PHONE #

EVMS Medical Group and its affiliates will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed protected information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Department \_\_\_\_\_

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*Office use only - Patient Revocation/Modification*

Date received: \_\_\_\_\_  
Staff initials: \_\_\_\_\_

Request received via  Letter  Telephone  
(Attached copy of any written correspondence)