Michael E. Mandis, MD
2236 Vadalabene Drive, Suite 2
Maryville, IL 62062

Authorization of Communication to designee(s)

Patient name:______________________________ Date of birth:____________________

Social security#_______-_____-_______
Address:____

Release of information to family, friends and/or caregivers. Our practice may release your Protected Health Information to a person that is involved in your care, or to someone who assists in taking care of you. We may release this Protected Health Information only with a written authorization from you. Please list below the names and information of anyone who may receive your health information.

Designee name___________________________________ Date of birth:________________

Phone#______________________________ Relationship__________________________

Designee name___________________________________ Date of birth_________________

Phone#______________________________ Relationship__________________________

Designee name___________________________________ Date of birth_________________

Phone#______________________________ Relationship__________________________

I understand that information regarding physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, HIV testing and AIDS diagnosis or treatment must have a separate authorization before this information can be released. I understand that I may revoke this authorization at any time through written notice.

Signature:_________________________________ Date:______________________