Designate A Health Care Agent Choose someone to act for you if you can't

Patient Name:			/Birthdate://			
Firs			ast	Month Day	Year	
I am requesting th	at the following bo	e made my primary	& alternate hea	Ith care repre	esentative:	
Primary						
First	Mid	ddle L	ast			
Address						
City		State	ZipCode	e		
Email						
Cell Phone		Other Phone				
Alternate			Phone	e		
First	Middle	Last				
Patient Signature				_// n Day Year		
		Clinic Use Only	, ,			
Clinic Name						
Privacy Officer _						
pr	inted name		signature			