3. Designation of Certain Relatives, Close Friends, and Other Caregivers:

I agree that The Office of Edred V. Shen, MD may disclose certain health information to a family member, close personal friend, or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, The Office of Edred V. Shen, MD will disclose only information that is directly relevant to the person(s) involvement with my health care or payment relating to my health care. I designate the following person(s) listed below as person(s) involved in my health care or payment relating to my health care for the purpose of The Office of Edred V. Shen, MD to make the type of disclosures listed above. I understand that I am not required to list anyone and that I may change this list at any time in writing.

Name: ______________________________ DOB: __________

Relationship: ____________________ Phone Number: ______________

Name: ______________________________ DOB: __________

Relationship: ____________________ Phone Number: ______________

Name: ______________________________ DOB: __________

Relationship: ____________________ Phone Number: ______________

Name: ______________________________ DOB: __________

Relationship: ____________________ Phone Number: ______________

______________________________ ____________________

Signature of Patient/Parent/Guardian Date