Elena Sanders, MD, P.C.

400 Seaview Ave
Staten Island, NY 10305
Phone 718-980-0055 Fax 718-980-0058

Patient Representative Designation Form

Patient Name: _____

Date of Birth: _____Phone: _____

Address: _____

City: _____State: _____Zip: _____

Social Security Number: _____

I hereby give permission to Dr. Elena Sanders, her employees and representatives of the practice, to share all aspects of my medical care and treatment, and to discuss all payment and insurance issues with the following individual:

Name: _____

Date of Birth: _____ Phone:_____

Address: _____

City: _____State: _____Zip: _____

Relationship to the patient: _____

_____ _____

Signature of patient or legal representative Printed Name

Date: _____