

VIRGIN ISLANDS UROLOGIC CENTER, INC.
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AUTHORIZATION LETTER

I, _____ authorize employees of the V.I. Urologic Center to communicate with the following family members, and/or health care aids to help me with my office visits, obtaining prescriptions, and preparing for procedures and/or surgeries.

I further authorize the following family members, and/or health care aids to assist me in creating a personalized User ID and Password for the purpose of accessing the Meridian EMR Patient Portal website to obtain my personal medical information electronically through the internet:

| | |
|--------------------|------------|
| ____ Wife/Husband | Name _____ |
| ____ Son/Daughter | Name _____ |
| ____ Mother/Father | Name _____ |
| ____ Other | Name _____ |

I further authorize you to discuss my medical conditions with the persons (s) named above. This authorization is good for 1 year from the date signed below. It must be renewed annually.

Signature: _____

Print Name: _____

Date: _____

Witness: _____

Date: _____

*I understand that any authorized person must show I.D. when inquiring about your health.