Authorized Representative Form for Medical

Patient Information

Full Name: _____

Date of Birth: _____

Gender: [ ] Male [ ] Female

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Authorized Representative Information

Full Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Authorization Details

I, _____ (Patient's Name), authorize the above-named representative to access my medical records and make medical decisions on my behalf.

This authorization is valid from _____ (Start Date) to _____ (End Date).

Limitations (if any):

Patient Signature

Signature: _____ Date: _____

Witness Information

Name: _____

Signature: _____ Date: _____