

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative regarding

- ☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.
- ☐ Only the following types of information:

The above medical information shall only be released to the following persons:

- ☐ I do **NOT** authorize this facility to speak with any family members or personal representatives regarding medical information **OR**
- ☐ I give permission for this facility to speak to the following people:

Family Member / Personal Representative

Relationship

_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

- ☐ Until revoked in writing.
- ☐ Until _____, 20____

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature _____

Signed this _____ day of _____, 20____