Authorization to Share Healthcare Information with Legal Representative

Patient Name

Full name

Date of Birth

MM/DD/YYYY

Authorized Legal Representative

Full name

Relationship to Patient

E.g. attorney, guardian, etc.

Information to Be Disclosed

Describe types of information or check 'All medical records'.

Purpose of Disclosure

Legal consultation, advocacy, etc.

Expiration Date or Event

MM/DD/YYYY or specific event

Additional Restrictions/Instructions

(Optional)

Signature of Patient or Legal Representative

_____

Date

_____

Note: You may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken based on this authorization.