

Date: [Date]

To: [Name of Doctor/Clinic/Medical Facility]

Address: [Facility Address]

RE: Patient Authorization for Family Member Involvement

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Medical Record Number: [Optional: MRN Number]

To Whom It May Concern,

I, [Patient's Full Name], hereby authorize [Family Member's Full Name], who is my [Relationship, e.g., Daughter/Spouse/Son], to act on my behalf regarding my medical care and treatment.

I grant the aforementioned individual the authority to:

- Discuss my medical condition, diagnosis, and treatment plans with my healthcare providers.
- Access and receive copies of my medical records and test results.
- Schedule or cancel appointments on my behalf.
- Pick up prescriptions or medical supplies.
- Make medical decisions on my behalf if I am unable to do so.

This authorization is valid from [Start Date] until [End Date or "further notice"]. I understand that I may revoke this authorization in writing at any time.

Please update my medical file to reflect this authorization. If you have any questions, I can be reached at [Your Phone Number].

Sincerely,

[Patient's Signature]

[Print Patient's Name]

Witness/Notary (if required):
