Power of attorney (POA) Release of Information

Must indicate financial agent if patient does not manage finances independently

1) Name: ____

_____Health Care   _____Financial   _____Both Health Care/Financial

_____Mental Health Records   _____Alcohol/Drug abuse treatment

_____Communicable diseases (including HIV and AIDS) _____Other

Relationship to Patient: _____________________________________

Phone Number: ____

Email Address: ____

Billing Address: ____

______ I **hereby give consent, to the person named above, to receive information regarding my medical condition and allow access to my patient portal.**

____ ______________

Signature of Patient Date

____ ______________

Signature of Legally Authorized Representative/Relationship Date