Beneficiary Restricted Access Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Beneficiary's Full Name], born on [Date of Birth], hereby grant authorization for restricted access to my health benefits information as specified below:

Authorized Individual

Name: [Authorized Individual's Full Name]

Relationship: [Relationship to Beneficiary]

Contact Information: [Phone Number, Email Address]

Scope of Authorization

This authorization allows the above-named individual to access the following information:

- Health benefits eligibility
- Claims status and history
- Medical treatment details
- Any other necessary information pertaining to my health benefits.

This authorization is valid until [Insert Expiration Date] or until I revoke it in writing.

Thank you for your attention to this matter.

Sincerely,

[Beneficiary's Signature]

[Beneficiary's Printed Name]

[Beneficiary's Address]

[Beneficiary's Phone Number]