Beneficiary Identification Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], residing at [Your Address], hereby authorize the disclosure of my healthcare directives and related information to the following individual(s):

Beneficiary's Name: [Beneficiary's Full Name]
Relationship to Beneficiary: [Relationship]
Contact Information: [Beneficiary's Contact Information]

This authorization is granted for the purpose of enabling the above-named individual to make informed decisions regarding my healthcare based on my directives. I understand that this authorization allows for the examination and copying of my healthcare information as necessary.

This authorization is effective immediately and shall remain in effect until [Insert End Date or State "until revoked by me in writing"].

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Phone Number]
[Your Email Address]