Medical Representation Authorization Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], the undersigned, hereby authorize [Authorized Person's Name] to act on my behalf as my medical representative. This authorization includes, but is not limited to, accessing my medical records, making decisions regarding my treatment, and communicating with healthcare providers.

Details of the patient:

- Name: [Patient's Name]
- Date of Birth: [Patient's DOB]
- Address: [Patient's Address]
- Phone Number: [Patient's Phone Number]

Details of the authorized representative:

- Name: [Authorized Person's Name]
- Relationship: [Relationship to Patient]
- Contact Information: [Authorized Person's Contact Information]

This authorization is valid until [Expiration Date].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Name]

[Your Contact Information]