Customer Account Management Authorization

Date: [Insert Date]

To:

[Healthcare Provider's Name]

[Healthcare Provider's Address]

[City, State, ZIP Code]

Dear [Healthcare Provider's Name],

I, [Your Name], hereby authorize [Authorized Person's Name] to manage my account with your organization on my behalf. This includes, but is not limited to, discussions regarding my health records, billing inquiries, and appointment scheduling.

Patient Information:

Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Account Number: [Your Account Number]

Please provide [Authorized Person's Name] with the necessary information and access needed to assist with my account management. This authorization is effective from [Start Date] and will remain in effect until [End Date] or until revoked by me in writing.

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]