Personal Representative Authorization Form

Patient Name:_____
First Middle Last

Date of Birth:_____

Address 1:_____

Address 2:_____

City: _____ State:_____ Zip Code:_____

Personal Representative Name:_____

Personal Representative Address:_____

Personal Representative Phone: _____

Are there any limitations on what can be discussed: circle one Yes No

Document *any limitations* on issues your personal representative may discuss with this office. Please Be specific.

This form will remain in effect until the patient is no longer a patient of Behm Family, Practice, LLC or until we receive a notice that this in no longer in effect.

REQUIRED SIGNATURE:

Patient's Signature _____

Date _____

You may revoke this form at any time. However, it must be in writing or request a revocation of personal representative form from our office.