**[Your Name]**

[Your Address]

[City, State ZIP Code]

[Phone Number]

[Email Address]

**[Date]**

**To Whom It May Concern**,

**[Your Name]** hereby authorizes **[Authorized Person's Name]** to access my medical information, communicate with my healthcare providers, and make healthcare choices on my behalf.

The following tasks are included in the scope of this authorization:

* Accessing my medical records
* Speaking with my healthcare providers
* Making decisions about my treatment and care

Unless otherwise specified, this authorization is valid from **[date]** to **[date]**, after which it will expire.

Please remember that **[Permitted Person's Name]** is not authorized to make recommendations about any medical procedures that I have previously expressed my disapproval of.

I have given [Authorized Person's Name] a copy of this authorization letter and preserved a copy for my records.

**Sincerely,**

**[Your Name]**

**[Your Signature]**

**Notary Public's Signature & Seal**

**[Date]**

**\*It is critical to remember that the letter should be clear, simple, and easy to comprehend and that you should be extremely particular about the extent of the authorization and the time limit if one exists.**