



101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • (256) 256-1000

112 LEGALLY AUTHORIZED REPRESENTATIVE DESIGNATION

Patient Full Name: _____
(Name of a minor child or patient who is physically/mentally incapacitated or deceased).

Date of Birth: _____ SS# (Optional / Last 4 digits) _____

PATIENT IS A MINOR CHILD OR IS PHYSICALLY OR MENTALLY INCAPACITATED:

The following classifications are in order of priority. Please check the applicable classification:

1. _____ A court-appointed guardian or a guardian appointed by a person legally authorized to appoint a guardian under the statute.
2. _____ An agent appointed by the patient in accordance with an Advance Directive, Living Will and/or a Durable Power of Attorney for health care.
3. _____ Spouse of patient (including common law spouse).
4. _____ Son or daughter nineteen (19) years or older of the patient.
5. _____ Parent of the patient. Mother Father
6. _____ Brother or sister aged nineteen (19) or older of the adult patient.
7. _____ Any one of the patient's surviving adult relatives who are of the next closest degree of kinship to the patient. Specifically, I am the _____.

Signature _____ Date _____ Time _____

By checking one of the above, I hereby certify that I am the legally authorized representative of the named minor child or incapacitated person and to my knowledge, there is no person with a higher classification. I thereby am authorized to receive or to request medical records on behalf of the above named person.

PATIENT IS DECEASED:

1. _____ Executor/administrator of the estate
2. _____ Family member or other who was involved in care or payment for care of the decedent prior to death.

Signature _____ Date _____ Time _____

By checking one of the above, I hereby certify that I am the executor or administrator of the estate or was involved in the care or payment for care of the decedent prior to death. I thereby am authorized to receive or to request medical records on behalf of the above named person.

Print name: _____ Phone Number: _____

Address: _____ City, State, & Zip Code _____

_____ Date _____ Time _____

