Athens-Limestone Hospital

700 West Market Street, Athens, AL 35611

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 _____

_____ _____ _____

Witness' Signature Date Time

Reviewed: August 2000, Revised: July 2005, April 2013, March 2014
FORM # NS 285850

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