LEGAL AUTHORIZATION

To Whom it May Concern:

____ has my
(Name)

permission to talk with the administration and staff of ___________

____,
(Facility)

as well as any other individual(s) deemed necessary regarding the care

of ________________________________ and to facilitate resolution of the
(Resident)

the complaint(s) filed.

_______________________________________ has my permission to view
(Name)

the medical/social records of ____________________________________.
(Resident)

My relationship to ________________________ is _________________.
(Resident) (Relationship)

I am legally authorized to give such permission. ______ yes _____ no

____
Legal Representative Signature

____

Date

(Form appropriate for Guardians, Health Care Powers of Attorney & Durable Powers of Attorney ONLY)

DHHS-DAAS-9116

3/06