Open Arms
Patient Advocacy Society

01/23/2021

LETTER OF AUTHORIZATION FOR RELEASE OF INFORMATION

I, ________________________________, hereby authorize the following
(Name of client or holder of client's PoA)

institutions and agencies
____
____
____
(Name of institutions or agents)

to release to OPEN ARMS PATIENT ADVOCACY SOCIETY, their advocates or delegate, any and all information related to the following (Describe particulars of medical situation, including approximate timeline and about whom the incident occurred):
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____________________Date_________Print Name____________________
(Signature of client)

Address of Client:

____

____

Open Arms Patient Advocacy Society

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