Power of Attorney for Protected Health Information

Patient Advocate	Name	Phone No.
	Date of Birth (Alien Registration No.)	Relationship with power of attorney grantor
	A d d r e s s	
Power of Attorney Grantor	Name	Phone No.
	Date of Birth (Alien Registration No.)	
	A d d r e s s	

I (power of attorney grantor) now grant all powers of attorney to the authorized patient advocate mentioned above to do on my behalf in respect of viewing and receiving copies of my health information in accordance to article 21 clause 3 and article 13 clause 3 of the medical law.

_____/_____/_____(date/month/year)

Grantor_____ (signature)