



PATIENT REPRESENTATIVE AUTHORIZATION

Print Legal Name _____
Date of Birth

I give permission to the physician and staff of All Sports Medicine of Boulder, PC to discuss information regarding my healthcare with family member(s)/representative(s) listed below:

Name/Relationship

Name/Relationship

I authorize the family member(s)/representative(s) listed below:

Name/Relationship

Name/Relationship

...to pick up on my behalf

___ Prescriptions

___ Medical records

___ Other (specify) _____

Date _____
Patient Signature