



**Power of Attorney
for medical & healthcare decisions
Information Sheet**

***** Please list the Responsible Party and/or Power of Attorney information below. This information MUST be filed out so that it can be noted in the patient's chart *****

Responsible Party/P.O.A. (Person responsible for medical bills and receiving correspondence on behalf of the patient):

Name:

Address (where you prefer to receive correspondence):

Street

City, State, Zip

Telephone Number: _____ - _____ - _____ Cell Home Work

Alternate Number: _____ - _____ - _____ Cell Home Work

OK to receive:

Statements/Bills Letters Calls Other Correspondence

Patient's Name _____

Signature _____

Date Signed ____/____/____