



*Personal Care Associates*

**Authorization to Treat**

I, \_\_\_\_\_ hereby authorize Personal Care Associates and/or its representatives to treat any ongoing, present and future illnesses deemed necessary, on my behalf. I further authorize the release of any necessary information, including medical information for this or an related claim to my insurance carrier.

I, do \_\_\_\_ or do not \_\_\_\_, have a Living Will established, I will make a copy available to Personal Care Associates, to become a part of my medical record.

Power of Attorney has, \_\_\_\_ or has not \_\_\_\_ been established, I will make a copy available to Personal Care Associates to become part of my medical record.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked, be me at any time in writing.

Printed Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_