Appointment of Authorized Representative and Consent

First Name: Consent 1
Last Name: Test
Date of Birth: 11/1/2001
Street Address: 1600 Pennsylvania Ave
City, State and Zip Code: District of Columbia AK 55555

I authorize King's Daughters Medical Center and their agents, and third-party contractors or service providers, the right to: 1) Use the documents and information I provide to determine my eligibility for financial assistance, apply for financial assistance programs on my behalf, submit claims on my behalf, and track any awards I may receive. 2) Obtain copies of my past two years tax returns from the Internal Revenue Service, and/or obtain my consumer report from a consumer reporting agency to be used in the eligibility screening. 3) Contact me to facilitate the eligibility screening, financial assistance enrollment process, claims submission, or to notify me of an award. I understand that I am not obligated to grant consent, and that healthcare providers or insurers will not condition my medical treatment or insurance benefits on my granting consent. I may revoke consent by mailing a revocation to 617 23rd st. Ste 19, Ashland, KY 41101

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn I certify that the documents and information I provide in this application are complete and accurate to the extent of my knowledge.

Signature of Patient or Patient Representative

If other than Patient, specify relationship to Patient: _____

Date 11/26/2024