21ST CENTURY MOVES

Dependent's Representative Authorization

I, _____ , Parent / Guardian for Claimant, _____.

address:_____

Grant Authorization to:
Accident Victims Alliance LLC
245 East Centennial Pkwy, #3116
North Las Vegas, NV 89084
to act as my Health Manager Advocate (HMA)

I give my Health Manager Advocate the maximum power under law to perform the following specific acts on my DEPENDENT'S behalf: *Patient Advocate*

My HMA accepts this appointment and agrees to act in my best interest as he or she considers advisable. This AUTHORIZATION may be revoked by me at any time and is automatically revoked upon my death or incapacitation. My HMA may be compensated for his or her services and shall not be liable to me, my estate, heirs, successors, or assigns for acting or refraining from acting under this document, except for willful misconduct or gross negligence. Any third party who receives a signed copy of this document may act under it. Revocation of this document is not effective unless a third party has actual knowledge of such revocation.

Dated _____, 2015

_____
Signature of Person Granting AUTHORIZATION

_____
Printed Name of Person Granting AUTHORIZATION

I accept my appointment as Health Manager Advocate

_____
Signature of Person Granted AUTHORIZATION

_____
Printed Name of Person Granted AUTHORIZATION