A U T H O R I Z A T I O N

Date (present date)

To: DWSD

(address)

I (name of patient), hereby authorize my (name of wife/husband) whose signature appears below to process my request for Medical Assistance from DSWD, in connection to my hospitalization at (name of the hospital and address) on (date of hospitalization).

(He/She) is authorized further to submit the requirements, claim and sign any documents relative to the release of my Medical Assistance in my behalf.

Should you wish to verify the authenticity of this authorization, you can contact me at: (cellphone number).

Thank you.

Authorized by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient name & Signature)

Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature Over Printed Name)