Medical Record Number:______________
(hospital staff to complete)

This authorization expires on (please provide a date or an event when the authorization will no longer be valid)

12-1-09

If no date is specified, this authorization will automatically expire in six (6) months from the date of my signature below.

[signature] 8-4-09

Signature of patient or personal representative — Date

Tiffany Kay Anderson

(print name of personal representative)

Self

Relationship of personal representative

This section to be completed by Dameron staff:
Name and signature of person receiving information and verification of identification of the requestor:

☐ I have verified the requestor's identity by the following:

☐ Valid picture identification from state of federal government

☐ Copy of death or birth certificate

☐ Properly executed power of attorney

☐ Other documentation

☐ I provided the requestor with a copy of the information sheet regarding the price for copies (if applicable) and the timeframe to expect a response to the request.

☐ I checked the authorization to ensure that all items have been addressed

Additional information regarding this request:

Name (please print) — Signature — Date

AUG 27 2009