in my own words®
video advance directive recording service

Consent To Release Information

I _____ _____
Print Name *Social Security Number*

hereby give my permission for In My Own Words® Advance Directive Video Recording Service to exchange information with the following individual or organization:

Name _____

Address _____

Telephone _____

Fax _____

Email _____

Relationship to you

Family ☐ Attorney ☐ Health care agent ☐ Physician ☐

Other (please describe) _____

This authorization will go into effect as soon as we receive it. You can revoke it at any time by writing us a note.

_____
Print Name

_____ _____
Signature *Date*