

Financial Authorization Letter for Managing Medical Financial Assistance

Emily J. Walker
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Date: October 16, 2024

To:
City Hospital Financial Assistance Department
123 Medical Center Drive
Chicago, IL 60601

Subject: Authorization to Manage Medical Financial Assistance on My Behalf

Dear Financial Assistance Officer,

I, Emily J. Walker, authorize Michael R. Walker to manage all aspects of my medical financial assistance due to my current hospitalization and treatment.

Authorized Person's Details:

- **Full Name:** Michael R. Walker
- **Relationship to Authorizer:** Husband
- **Address:** 120 Greenway Lane, Chicago, IL 60601
- **Phone Number:** (555) 987-6543
- **Email Address:** michael.walker@email.com

Scope of Authorization:

I authorize Michael R. Walker to:

- Apply for financial assistance programs on my behalf
- Access funds and manage payments for my medical expenses
- Communicate with the hospital's financial assistance team and any associated institutions
- Complete all necessary documentation related to my financial aid

Details of Medical Financial Assistance:

- **Institution/Program Name:** City Hospital Financial Assistance Program
- **Patient ID Number:** CH456789
- **Type of Assistance:** Emergency Medical Aid and Hospital Bill Assistance

Duration of Authorization:

This authorization is effective from October 16, 2024, until January 31, 2025, or until revoked by me in writing.

For any further questions or verification, please contact me directly at (555) 345-6789 or emily.walker@email.com.

Signature of Authorizer: _____

Printed Name: Emily J. Walker

Date Signed: October 16, 2024

Signature of Witness (if required): _____

Printed Name of Witness: John D. Lee

Date Signed: October 16, 2024

Notary Public Signature (if required): _____

Notary Seal: _____

Date: October 16, 2024

Thank you for your understanding and support.

Sincerely,

Emily J. Walker.