

Your Loved One's Name Here  
His/Her Number, (USCF/CUCF)  
PO Box (165300/550)  
(Salt Lake City/Gunnison), UT (84116/84634)

## Medical Power of Attorney

This document authorizes and directs employees of the Utah Department of Corrections, including Clinical Services (Medical Department), and/or other prison personnel, to release to **Your Name Here** any and all documents and other materials in their possession pertaining to me or my health care.

This document authorizes and directs doctors, nurses, case workers or other prison personnel who have knowledge of, or who have addressed or treated my health conditions, to release to **Your Name Here** or his agent or attorney, any documents pertaining to me or my health care, and to disclose to him any confidential information or privileged communications pertaining to my health and well-being.

This document authorizes **Your Name Here** or his agent or attorney to communicate with any persons or organizations involved in health and/or medical fields regarding the evaluation, progress, and/or status of my request for assistance with my medical concerns.

In all other respects, my interactions with **Your Name Here** will remain confidential.

This document authorizes **Your Name Here**, or his agent or attorney to communicate with any persons or government agencies having information relevant to the evaluation of my medical condition, including, but not limited to: employees of the Utah Department of Corrections, including members and staff of Clinical Services (Medical Department) and/or outside providers of medical services. This document further authorizes **Your Name Here** to examine, receive, and/or photocopy, and/or scan onto a computer and/or USB or other storage device any and all documents pertaining to me or my case that are in the possession of such persons or agencies.

I understand that **Your Name Here** is not qualified to give legal advice, and is only gathering information for evaluation purposes. This authorization serves as authorization for **Your Name Here** for 10 years from the date this document is signed, unless authorization is withdrawn in writing.

Signed in the presence of a NOTARY, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
day month

Signature \_\_\_\_\_

Please Print your name \_\_\_\_\_