Access / Accès
OAP / POSA

Substitute Decision Maker Authorization

I, _____
(please print name)

am capable of making decisions for myself about health care services and how my personal information is collected, used, and disclosed. Capable means that I can:

- understand the information that is relevant to deciding whether to consent; and
- understand the consequences of giving, withholding or withdrawing the consent.

I authorize _____
(please print name)

to act as my substitute decision maker and provide consent on my behalf to register with AccessOAP.

Date: _____

Signature: _____

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