

Letter Of Support

Provider of Assistance: _____

Address: _____

To Premier Radiology:

This is to advise that (*patient's name*) _____ receives little or no income and I am assisting with his/her living expenses. He/She has little or no obligation to me.

By signing and having this statement notarized, I agree that the information given is true to the best of my knowledge.

Signature of Authorized Personal Representative

Date

Your signature must be witnessed by a notary

Sworn to and subscribed before me on the _____ day of _____ 20_____.

Notary at Large

Commission Expiration Date

Premier
Radiology



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