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

Revised 5.6.2021