Letter of Diminishing Abilities

Request and Authorization to Disclose Client Information

Security Financial Management
A BLUESPRING WEALTH PARTNER

INSTRUCTIONS: This form will be completed by the client and a witness before any information is provided to the parties identified below. The witness must be someone other than the advisor and other than the person being granted authorization. This original form must be retained.

Due to privacy laws, written authorization is required to share your financial information with a third party. This form is used to document your request that your financial information be shared with a third party, such as attorney, accountant, or family.

I, _____, give representatives of Security Financial Management, Inc., permission to contact the person(s) listed below and/or my durable power of attorney should Security Financial Management, Inc., believe my judgement has been impaired by a change in my physical, mental, or, cognitive abilities.

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____

PHONE: _____

EMAIL: _____

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____

PHONE: _____

EMAIL: _____

I make this request and authorization with the understanding that disclosure of my financial information by Security Financial Management, Inc., to the person of entity identified above will involve disclosure of my nonpublic personal information otherwise protected from disclosure by federal and state privacy laws. I understand that this authorization will remain in effect until it is specifically revoked by me in writing.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Witness Signature Date