Disclosure Authorization

Date: _____

With this authorization, I give permission to disclose my medical information to the following family member(s), friend(s), or other persons. I understand that I may revoke this authorization at any time and it is my responsibility to update this information due to any changes. I also understand that my medical information may be disclosed without my authorization in times of emergency or it is reasonably determined to be in my best interests to do so.

Patient Name:

_____

Patient Signature or Authorized Patient Representative:

_____

☐ I do not wish to have my medical information disclosed to anyone other than myself.

PERSON(S) THAT MAY RECEIVE MY HEALTH INFORMATION

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____