



Disclosure Authorization

Date: _____

Patient Account: _____

Patient Name: _____

Names of Family and/or friends we may discuss your treatment/health with:

_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____

Patient/Legal Representative signature: _____

Relationship to Patient: _____

Date: _____