

**CONSENT TO SHARE HEALTH INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

My physician and staff may discuss my medical care with the person listed below:

Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_