Information Authorization Form

We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, unless you specifically instruct us to do otherwise.

Please list anyone you specifically *do* want us to share your information with below:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
(Examples: Husband, Wife, Insurance Company, etc…)

By signing below you *are* allowing us to share personal information with the above listed people (if any changes in this information you will need to fill out a new form in person).

Signature: _____ Date: _____