



## 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: \_\_\_\_\_