



CONSENT DISCLOSURE

I, _____ hereby authorize the following people
Name of Patient
to have access to my medical information, appointment times, financial data and any
other pertinent data on my behalf via telephone or in person.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand this consent is valid until further revoked by me.

Patient Signature Date