Compassion Care Family Practice, LLC

Authorization to Share Medical Information

Patient Name:____

Date of Birth:_________________________

Social Security Number:________________________

I authorize sharing medical information with the following:

Name:_________________________________ Relationship:________________________________

Home Phone:____________________________ Cell Phone:________________________________

Name:_________________________________ Relationship:________________________________

Home Phone:____________________________ Cell Phone:________________________________

I authorize sharing of the following information (please check all that apply)

____ No information can be shared

____ Any information can be shared

____ Can authorize release of my medical records or obtain copies of my medical records

____ Billing information

____ Other (please specify)____

This authorization will remain in effect (please check only one):

____ From the date this is signed until (date) ____

____ Until I cancel this authorization in writing

____ Until the following occurs (please specify)____

By signing this I authorize the disclosure of all information checked above. I acknowledge I have reviewed and understand this authorization form.

Signature: ____ Date: _______________________