ORCHARD MEDICAL GROUP
FAMILY MEDICINE

Authorization to Share or Discuss Patient Information

I, _____DOB: _____/_____/_____
authorize Orchard Medical Group to share and discuss my medical care and treatment details with the person(s) listed below while I am under the care of Orchard Medical Group or hospitalized.

This authorization will remain in effect until I provide written notice of revocation.

Authorized Individual(s) for Information Sharing

Name: _____

Relationship: _____

Telephone Number: _____

Name: _____

Relationship: _____

Telephone Number: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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