Consent/Release

To help my practitioners provide me with coordinated, consistent health care, I consent to their sharing my medical records and discussing my case with each other. My medical records may be sent to a consulting specialist if necessary. I understand that other than this, my records and case will be held in the strictest confidentiality.

Name _____ Date _____

Name of Practitioner: Phone # Fax # Date care began/ended

I give permission for the above providers to discuss my medical condition and treatment plan with the significant others in my life listed below.

I understand that if, at any time, I no longer feel that it is appropriate for anyone listed to have access to such information, I need only verbally request that they be deleted. At that point all information sharing will cease with the stipulated person and a new consent/release form will be made available to me to verify that I have made the decision to exclude them from sharing confidential information regarding my care.

Name: Contact information: