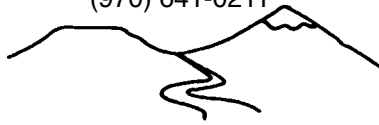


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DISCLOSURE AUTHORIZATION

Patient Name: _____

Names of family and/or friends we **MAY** discuss your treatment/health information with:

_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____

For privacy reasons, please list telephone numbers where we **MAY** leave messages:

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative, what is your relationship to Patient: _____