GUNNISON VALLEY
FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

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: _____