**CONSENT TO SHARE**

**Gary S. Ruoff, D.O.**

**201 S. Garfield Avenue**

**Traverse City, MI 49686**

 The practice may share my medical information with the following individual (s) with or without my presences, including but not limited to telephone, voice mail, fax, e-mail or regular mail.

\*These are not Emergency contacts. But rather, Should they call, can we talk to them, or can they pick something up for you?

 Please do NOT disclose my medical information to anyone. (Including my emergency contact, on file with HIPPA form)

**Name: Relation: Phone:**

**Name: Relation: Phone:**

**Name: Relation: Phone:**

I have read and agreed to allow the individual (s) listed above to participate in discussion and/or pick up of any medical related items. I understand that this consent may be revoked at any time by written notice to the practice.

Patient name: Birth date:

Patient Signature:

Witnessed by: Date: