CONSENT TO SHARE*

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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:_____