## Castle Rock Family Physicians, PC

# Disclosure Authorization

Date:_____ Patient Account:_____

Patient Name:_____

Names of Family and/or friends we **may** discuss your treatment/health with:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Patient/Legal Representative signature:_____

Relationship to Patient: _____ Date:_____