Castle Rock Family Physicians, PC

Disclosure Authorization

Date:_____

Patient Name (Print):_____ Date of Birth:_____

Below are names of family members and/or friends I authorize/give permission for you to discuss my medical treatment/health, and test results with. (This includes genetic test results unless you check NO to genetic testing results below): (Please sign and date the bottom of this form)

Genetic Testing (YES)_____ or (NO)_____

I do NOT wish for Castle Rock Family Physicians staff to discuss my medical treatment/health, and test results with anyone but me_____. (Please sign and date the bottom of this form)
(Initial)

Name: (Print First and Last Name)	Relationship:	Phone Number:
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____

Dates: From_____To:_____

You may revoke your decision at any time by filling out a new Disclosure Authorization form.

Patient/Legal Representative signature:_____

Relationship to Patient: _____ Date:_____