Affix Patient Label

Name: ________________________ Date of Birth:_______________

Authorization to Share Medical Information

☐ I authorize Bronson Healthcare Group to share my:

- ☐ Personal and/or demographic information
- ☐ Medical information – excluding ____
- ☐ Billing/financial/insurance information
- ☐ All information

To the following individuals:

Name	Phone Number	Relationship to Me
Name	Phone Number	Relationship to Me
Name	Phone Number	Relationship to Me
Name	Phone Number	Relationship to Me

-OR-

☐ I do not authorize Bronson Healthcare Group to release any of my medical information to anyone, with the exception of coordination of benefits (i.e., insurance) or continuation of care (i.e., referrals).

This authorization will remain in effect until revoked in writing by the above listed patient.

____ ______________________________

Signature Date