



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

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