BRONSON	Affix Patient Label
	Patient 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
Name	Phone Number	Relationship to Me

This will remain in effect until a new Authorization to Share Medical Information form is completed. Individuals listed on previous form do not carry over. If you are adding someone or changing a phone number, ALL names must be rewritten.

Patient Signature: _____ Date: _____ Time: _____