Generations Med Clinic
Authorization To Share Information

Patient Information:
Name:
DOB:
Address:
Phone:
Email:

Designated Relative Information
Full Name:
Relationship to Patient:
Phone Number:
Address:

To Whom It May Concern,

I, _____ D.O.B _____, PHN:_____, hereby authorize (Generations med Clinic) and its healthcare providers to release, discuss and obtain all medical information related to my health with the above mentioned relative. For relaying health-related information to me in the event I am not physically present or unable to receive it directly. This may include, but is not limited to:

- Diagnosis and test results
- Treatment plans and progress
- Medication instructions
- Appointment details

Consent Terms:

- This consent does not authorize the designated person to make medical decisions on my behalf.
- This consent is valid until revoked in writing by me.
- I understand that I have the right to withdraw this consent at any time by providing written notice to the clinic.

Acknowledgment and Signature:
I understand the nature of this authorization and voluntarily provide my consent for the disclosure of my medical information under the terms described above.

Patient Signature: Witness Name & Signature (if required)

Date: Date: