



Patient Name _____
PLEASE PRINT

DOB _____

Telephone _____

Address _____

NOTE: This authorization does NOT allow for the sharing of copies from the patient's health record. If there is an anticipated need for copies of the patient's health record, our standard form must be completed and submitted to the medical record department.

I authorize SUNSET MEDICAL PRACTICE to discuss/share protected health information about me with the following individual(s) who are involved in my care. This authorization shall remain in effect for 6 months from the date signed.

NAME _____
PLEASE PRINT

TELEPHONE _____

ADDRESS _____

RELATIONSHIP _____

NAME _____
PLEASE PRINT

TELEPHONE _____

ADDRESS _____

RELATIONSHIP _____

SIGNATURE _____ DATE _____