

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Telephone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_




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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.

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I authorize SUNSET MEDICAL PRACTICE to discuss/share test results about me with the following individual(s) who are involved in my care. This authorization shall remain in effect for 2 years from the date signed.

NAME \_\_\_\_\_  
PLEASE PRINT

TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_  
PLEASE PRINT

TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_