Consent to share confidential medical information

To be valid, this form must be filled out COMPLETELY

Patient's Legal Name: _____

Date of Birth: _____

I HEREBY AUTHORIZE PSYCH360 TO SHARE MY MEDICAL RECORDS WITH THE FOLLOWING PEOPLE/ORGANIZATIONS:

FULL NAME: _____ RELATIONSHIP_____

FULL NAME: _____ RELATIONSHIP_____

FULL NAME: _____ RELATIONSHIP_____

FULL NAME: _____ RELATIONSHIP_____

I understand that I may cancel this consent at any time (by writing to Psych360), but that canceling it will not affect any information that has already been released

Signature: _____ Date: _____

Witness Signature: _____ Date: _____