



AUTHORIZED INDIVIDUALS FORM

Please list all individuals that are authorized to receive your medical information either verbal or written.

NAME	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient

Print Name

Date