CADENCE
HEALTH CENTRE

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____, authorize Dr. _____
to disclose my personal health information, consisting of:

o Appointment details

o Test results

o Other _____

o All of the above

To be given to: _____

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent.

I understand that this personal health information can be refused to be forwarded at the discretion of my physician, Dr. _____

PATIENT NAME:

PLACE CLINIC LABEL HERE

Signature of Patient: _____ Date: _____

Signature of Witness / Physician
Name:_____
Signature: _____ Date: _____

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