

Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____ Birth Date: _____

I HEREBY AUTHORIZE Cary Foot and Ankle Specialists TO SHARE:

- Any of my medical information
- My lab results
- My appointment times, dates, and reasons for the visits
- The medications I am taking
- Financial/Billing Information
- The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

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 Cary Foot and Ankle Specialist), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider to share my information with someone.

This authorization expires:

- When I cancel it in writing
- Specified Date: _____

If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian): _____*
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: _____ Date: _____