Dr Cory Tichauer and Associates

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Clinic Family/Friends/Provider Authorization Form

Patient Name: ___________________________________ Date of Birth: _____________

As a patient of Bear Creek Naturopathic Clinic, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends or another provider. Please list the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my current health status to be discussed with:

Name	Relationship	Telephone
________________________________	______________________	________________
________________________________	______________________	________________
________________________________	______________________	________________
________________________________	______________________	________________
________________________________	______________________	________________

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care. This may include potentially sensitive information such as drug use, psychiatric topics, or DNA test results.

Signature: ______________________________________ **____________________**

Patient/Responsible Party **Today's Date**

Print Name: ________________________; Relationship to patient ________________

Responsible Party

- ☐ **I decline to have my medical information discussed with any friends, family, or another provider.**