Authorization to Disclose (optional)

I, the undersigned, authorize Family Holistic Health to disclose my medical information and/or discuss my medical information with the following person(s):

Spouse/Partner:

Name: _____

Phone: _____

Children:

Name: _____

Phone: _____

Name: _____

Phone: _____

Please use the back of this form for additional children.

Friend/Relative:

Name: _____

Phone: _____

Name: _____

Phone: _____

Your name, printed: _____

Signature: _____ **Date**: _____

Family Holistic Health