Office use only:
EHR ____
EPM ____

Disclosure Form

Today's Date_____

Patient's Name (printed)_____
Last First Middle

Date of Birth_____ SS#_____ Phone #_____

Legal Guardian (if patient is under 18) _____
Last First Middle

Guardian's Relationship to the Patient _____

Due to Patient Privacy Laws, Complete Family Medicine, LLC can only share medical information with me, the Patient. The following is a list of those whom I give Complete Family Medicine, LLC permission to share my medical information (e.g. relative, friend, employer)

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

I understand that I have a right to revoke this permission at any time. I understand that if I revoke this permission, I must do so in writing and present my written notice to Complete Family Medicine, LLC. I understand that the revocation of permission will not apply to information that has already been released in response to this form. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that authorizing the disclosure of my medical information to the person(s) identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

Complete Family Medicine, LLC
PO Box 295
Kirksville, Missouri 63501
PH: 660-665-7575 FX: 660-665-7576

COMPLETE FAMILY MEDICINE