

# Medical Confidentiality Waiver Form

Patient Name:

Date of Birth:

Physician Name:

Recipient (Person/Organization authorized to receive information):

Type of Information to be Disclosed:

Purpose of Disclosure:

This authorization will expire on:

☐ I understand the information disclosed may no longer be protected and that I may revoke this authorization in writing at any time.

Signature of Patient/Guardian:

Date:

Submit