OAK GROVE FAMILY
MEDICAL CLINIC

Authorization for Family Members/Friends

Patient Name:_____ DOB: _____

Patient to complete the following:

I authorize _____
Names/Relationships

_____

_____

_____

for the following purpose:

_____

_____

_____

This authorization is valid from _____ and expires on _____.

I understand that I may refuse to sign this authorization.

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to informatiohn already disclosed while the authorization was in effect.

Signed: _____ Date: _____