Arthur Rosner, M.D.
Consent to release information

With the increasing awareness of patient's right to confidentiality, we are asking your preferences for sharing health information. This will give our physicians and staff guidance as to who should be allowed to receive information regarding your health care or appointments.

PLEASE SELECT ONE OF THE FOLLOWING:

☐ DO NOT discuss my medical condition with anyone other than my doctors and other health care professionals involved in my health care.

OR

☐ I, _____, give the physicians and office staff of Arthur Rosner, M.D. permission to discuss my health care information, appointments, etc with the following individuals:

Name: _____

Relationship: _____ Phone #: _____

Name: _____

Relationship: _____ Phone #:_____

Name: _____

Relationship: _____ Phone #:_____

_____ Date: _____

Signature of patient or patient representative