Genesee Medical Group

Patient Name: _____

Date of Birth: _____

Date: _____

I, the above-stated patient, authorize the following person to receive protected health information from the office of Genesee Medical Group, or any of the practicing physicians within. I understand that I may revoke these permissions at any time by notifying Genesee Medical Group by phone or in writing.

Name: _____ **Relationship:** _____

Address: _____

Phone Number: _____ **Email:** _____

Information authorized to review:

- ☐ **All Information**
- ☐ **Patient Portal Family Share Consent**
- ☐ **Health Only**
- ☐ **Billing Only (may disclose diagnosis)**
- ☐ **Other:**

_____ _____

Patient Signature Office Staff Signature