I,_____

hereby authorize Family Physicians provider(s) to disclose to the below designated family members, any and all medical information required to make medical decisions relating to my care.

I waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility, it's agents, and employees from legal responsibility arising from the release of the information.

The following listed family members may be informed of my medical conditions:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____

Patient Signature

_____ _____

Social Security Number Date

By State law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATIONTHAT COULD BE CONSIDERED INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASES, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").