Authorization for
Disclosure of Medical Information

Patient Name **(print)**: ______________________________

I understand as a participant in this Group Visit/Shared Medical Appointment, that I and other patients will discuss medical information in the presence of other patients, people, staff, and the clinician. I understand this model will provide me with the benefit of a visit with my provider and the added benefit of learning from other patients

I authorize ____ (provider(s) leading group visits) to share medical information pertaining to my current medical conditions with participants of this, and future, group medical appointments of which I am in attendance.

This authorization shall become effective immediately and shall remain in effect for 1 calendar year from the date of signature.

If I have medical concerns that are of a very private nature, I will request to discuss with the clinician in a private setting or will schedule an individual office visit. I will also respect the confidentiality of the other members of the group by not revealing medical, personal, or any other identifying information about others in attendance after the session is over.

I understand that I can obtain a copy of this authorization upon my request.

Signature: _________________________________

Date: _________________________________