Barry Fernando, M.D. and Coleene Fernando, M.D., P.C.

Disclosure of Medical Information

Consent: (check one)

_____ I authorize Dr. Fernando to disclose my medical information to the following person(s). I understand this consent is valid until I revoke the authorization in writing. Please list no more than two names.

Name Relationship Phone #

1. _____

2. _____

_____ I do not authorize Dr. Fernando to disclose my medical information to anyone other than those listed in compliance with the Privacy Practice.

Signature of Patient (or Guardian) _____

Printed Name of Patient (or Guardian) _____

Date _____