AUTHORIZATION TO SHARE MEDICAL INFORMATION
WITH FAMILY MEMBERS

CLIENT: _____

DOB: _____ SSN: _____

****

I hereby give my consent for Medical Rehabilitation Consultants, Inc. and my case manager,

_____, to share information with the following persons regarding my medical care, medical needs, and medical status.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that I may revoke this authorization at any time by notifying Medical Rehabilitation Consultants, Inc. in writing.

I agree that a photocopy of this consent be accepted if necessary.

_____	_____
Patient Signature	Date

IF MINOR, BY PARENT OR LEGAL GUARDIAN:

_____	_____
Parent/Legal Guardian Signature	Date

This authorization will expire in 90 days from the date signed.
111W. Cataldo, Suite 200 * Spokane, Washington 99201-3203 * 509-328-9700