Medical Pavilion Clinic 2525 Harbor Blvd.
Port Charlotte, Fl. 33952
(941) 629-9190

Permission to Disclose

To Whom It May Concern:

I hereby authorize the Medical Pavilion Clinic to discuss and disclose my Patient Health Information, including the diagnoses and records of my treatment or examination, with _____(name),_____(relationship).

This is effective from _____ to _____.

Signature: _____ Date: _____

Witness: _____ Date: _____