Hear in ARIZONA

Shared Information Consent Form

Patient Name: _____

Email Address: _____

Emergency Contact:

Name: _____

Phone Number: _____

Relationship to Patient: _____

Individuals you would like us to share your information with:

Name: _____

Phone Number: _____

Relationship to Patient: _____

Name: _____

Phone Number: _____

Relationship to Patient: _____

Name: _____

Phone Number: _____

Relationship to Patient: _____

Name: _____

Phone Number: _____

Relationship to Patient: _____

I consent to Hear in Arizona sharing information regarding my diagnosis and/or treatment plan with any of the above-listed individuals.

_____ _____

Signed Date

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