Foothills Medical Group
Olean General Hospital

Disclosure of Medical Information

_____ I do **not** object to my personal health information being disclosed to a family member, friend, or any individual involved in my care.

Please specify the names of any individuals to whom we may release your personal health information to:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

4. _____ Relationship: _____

_____ I **do** object to my personal health information being disclosed to a family member, friend, or any individual involved in my care.

_____
Patient Signature

_____
Witness Signature

_____
Today's Date