KIAMICHI
FAMILY MEDICAL CENTER

I, _____ hereby authorize Kiamichi Family Medical Center to share my medical and health information, in order to best coordinate my care, with the following people:

Name: _____ Relationship: _____

Telephone Number: _____ Cell Phone Number: _____

Address: _____

Name: _____ Relationship: _____

Telephone Number: _____ Cell Phone Number: _____

Address: _____

Name: _____ Relationship: _____

Telephone Number: _____ Cell Phone Number: _____

Address: _____

Name: _____ Relationship: _____

Telephone Number: _____ Cell Phone Number: _____

Address: _____

Signature: _____ Date: _____