Whole Health Wellness Center LLC • 231 Farmington Ave, Suite 201• Farmington, CT 06032

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Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____ Date of Birth: _____

I Hereby Authorize Whole Health Wellness Center to share: Any of my medical information, including information about:

- ___ Sexually transmitted disease (STD) testing and treatment
- ___ Mental health diagnoses and treatment
- ___ Pregnancy testing and prenatal care
- ___ Drug and alcohol use history and treatment
- ___ Birth control/family planning
- ___ My lab results (note: signing this form does NOT mean we will share result of STD or HIV/AIDS tests)
- ___ My appointment times, dates, and reasons for the visits
- ___ The medications I am taking
- ___ The following information (specify):_____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time in writing, but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone. This authorization expires: When I cancel it in writing or on the date of _____. If no expiration date is specified, this authorization will expire one (1) year after the date it is signed.

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian)*: _____ If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney) Witness: _____ Date: _____