Vance Medical
1001 N. Meridian Rd.
Meridian, ID 83642
Ph 208-258-7558 Fax 208-717-9595

CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION:
PATIENTS 18 YEARS AND OLDER

In order for Vance Medical to speak with anyone including a family member and/or spouse, this form must be filled out Completely.

Patients Name: ____

Patients Date of Birth: _________/______/________

_____ Only release information to me personally.

I hereby authorize Vance Medical to share the following information:

_____ My medical care and treatment plan

_____ Lab test results

_____ Appointment information

_____ Medications I am taking

_____ Mental Health

_____ All of the Above

With the following people:

Name ____Phone ___________________
Relationship ____

Name ____Phone ___________________
Relationship ____

Name ____Phone ___________________
Relationship ____

Name ____Phone ___________________
Relationship ____

_____ You have my permission to leave information on my answering machine regarding my medical care and test results.

Patient's Name: ____________________________________ Signature: __________________________
Date: ____________________________

This form is valid until three (3) years from the date it's signed.