# ROSEVILLE ENDOCRINOLOGY

508 Gibson Drive, #270, Roseville, CA 95678

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## PATIENT AUTHORIZATION FORM

Please complete this form if you would like us to be able to disclose the lab results or other health information to a specific family member or other individual. If you do not want any information disclosed to anyone other than yourself, please complete the appropriate area below.

Patient Name: ____________________________________________

I hereby authorize Dr. Manish Upadhyay to discuss my care and treatment with the following person(s).

Name: ______________________ Name: ______________________

Relationship to Patient: ______________ Relationship to Patient: ______________

Phone: ______________________ Phone: ______________________

I, ______________________ designate that ______________________ will be the spokesperson for my family, and have my permission to keep the family informed of my condition.

Patient Signature: ______________________________ Date: ______________

This authorization shall remain in effect from the original date signed above until ______________

____________________________________________

**OR**

I hereby authorize Dr. Manish Upadhyay to discuss my care and treatment with no one other than myself.

Patient Signature: ______________________________ Date: ______________