SUNCOAST
INTERNAL MEDICINE CONSULTANTS
A MULTI-SPECIALTY CLINIC

Healthcare Information Authorization Form

Name_____Date of Birth_____/____/_____

Email_____Cell #_____

I give authorization to Suncoast Internal Medicine Consultants to disclose information concerning my healthcare and to discuss my healthcare with the following persons:

Name of Authorized Person_____Relationship_____

Name of Authorized Person_____Relationship_____

Name of Authorized Person_____Relationship_____

Patients Signature_____Date_____