Medical Information Consent

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Sonoo Advani M.D, may disclose health information and medical records regarding my health and treatments to the designated person(s) listed below. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request.

Print Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient/Parent or Guardian **Today's Date**