UC Health

Disclosure to Family/Friends

I hearby authorize UC Health Weight Loss Center (Physician/UC Health Primary Care office) to discuss the following with the person/persons listed below.

- ☐ Condition/Treatment/Plan of Care
- ☐ Diagnostic Test Results
- ☐ Lab Results

Allowed Person/Persons

Name:	Relationship:

Do we have permission to leave messages/test results on voicemail/answering machine? ☐ Yes ☐ No

Patient Name/Legal Representative: _____

Patient Date of Birth: ____/____/____

Signature: _____

Date: ____/____/____

**If necessary, describe scope of authority to act for patient. Provide guardianship, executor of estate or power of attorney papers.