EAU CLAIRE MEDICAL CLINIC SC

A division of Oakleaf Clinics SC

FAMILY SHARED INFORMATION

Patient Name: _____ Date of Birth: ___/___/___

I hereby consent that my healthcare information may be shared both verbally and by mail with the following individuals:

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Signature: _____ **Date: ___/___/___**