WB University Hospital Behavioral Health
3535 W 13 Mile Rd, Suite 240
Royal Oak, MI 48073

MEDICAL INFORMATION CONSENT

Patient Name: _____ Date of Birth _____

I AUTHORIZE THAT ALL ASPECTS OF MY MEDICAL CARE, INCLUDING LAB / TEST RESULTS, MAY BE DISCUSSED WITH THE FOLLOWING PEOPLE:

NO ONE BUT MYSELF ( ) **Please check here if medical care is only to be discussed with the patient.**

Name: _____ Phone number: _____ Relationship: _____

Name: _____ Phone number: _____ Relationship: _____

Name: _____ Phone number: _____ Relationship: _____

SIGNATURE OF PATIENT (Parent / Guardian): _____ **Date**: _____